

**Bedside Nurses and the Restructuring of Healthcare:  
Identity, Power and Resistance**

by

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A thesis submitted in conformity with the requirements  
for the degree of Doctor of Education  
Department of Sociology and Equity Studies in Education  
Ontario Institute for Studies in Education of the  
University of Toronto

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Isolde Daiski, Doctor of Education, 2001  
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**Abstract**

This thesis examines the views and experiences of bedside nurses in the restructured Ontario healthcare system of the late 1990s. Amidst increasing routinization and deskilling many nurses were laid off and a nursing shortage was beginning to emerge. The twenty participants worked in a variety of hospital settings in a large Ontario city. During semi-structured interviews they shared their thoughts on the changes in work organization, staffing patterns, their own quality of work lives and patient care.

The theoretical framework for the design and analysis of the study is based on Michel Foucault's ideas of power and subjectivity. Power is seen as a productive force working through relationships between people which are inegalitarian and unstable by nature. Subjectivity is about how individualities are perceived and formed within competing discourses, past and present, including conscious self formation and 'self styling'. Recognition of how the dominant discourses interfere with practices considered ethical, such as caring, and devalue them, may become 'points of resistance'.

The findings were organized into three layers, each representing a chapter. In the first layer the work and staffing patterns of the restructured system are discussed. The second layer shows the nurses' relationships amongst themselves and with other groups in the workplace, including the 'games of power' in which nurses participate. The third layer deals with the participants' ideals of nursing, their disappointments, philosophies and collective strategies of proletarianization and professionalism. While uncomfortable and competitive processes are revealed, many traceable to historical roots and gendered expectations for medicine and nursing,

there are also signs of increasing mutual support and assertiveness.

Major themes that emerge are that nurses 'sit on the sidelines' and have no 'voice', while decisions are 'imposed from above'. Yet as active participants they also co-create their submissive positions. Recommendations for nursing's future, professionalism, recruitment and retention, education and further research are proposed. They include increasing the 'field of possibilities' through analysis of existing dominant discourses. More aware of their active participation in the ongoing relations of power, nurses may 'squeeze into spaces of freedom' that open up within the current crisis and thereby revalue nursing.

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Without the input and help of many others this project would not have been possible. I am deeply thankful to all the participants who took time out of their busy lives, to speak to me about restructuring and its impact on their work. Their care for and love of nursing was evident, as they shared their experiences and ideas with me. They helped to shed light on nursing practice at the bedside within the present context. I hope that their enthusiasm despite the many adversities they experienced, will be an inspiration to all nurses in these difficult times.

My committee members were a great source of support throughout the project. They encouraged me and challenged me to think more deeply about my analysis and offered guidance by sharing their knowledge and insights. From the time when the project took shape to its completion, my supervisor, Dr. Sandra Acker was there to support me and provide valuable feedback. She shared her vast experiences and love for research with me and nurtured hope along the way. Dr. Kari Dehli was the teacher who introduced me to and helped me to appreciate Foucault's thoughts. Dr. Adrienne Chambon discussed her own research, ideas and understanding of Foucault's work with me along the way and fostered some new insights that helped me organize my findings. My external examiner, Dr. Meryn Stuart, added feedback based on her nursing knowledge, providing me with ideas in regards to future projects. Dr. Roxanna Ng, my internal examiner, also challenged me to think about directions for further research.

To my children Monika and Martin who supported me along the way, encouraged me and put up with my many absences when the project took over most of my free time, I am also deeply grateful. They showed me patient understanding throughout the years I was in school.

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Lastly I am thankful to my many friends and colleagues, who listened to the stories and musings about my thesis and shared their own ideas with me. All these many others who contributed in producing this work, deserve to share the credit.

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## CHAPTER 1

### INTRODUCTION AND BACKGROUND

#### What Led to this Project

This project is my doctoral dissertation. In its introductory chapter I want to give an overview of how it evolved, its major concepts, research questions, conceptual framework and how it is organized. I am exploring the perceptions hospital staff nurses hold of themselves and their nursing practices within the context of the current 'restructuring' of the healthcare system. My particular interest lies in how the bedside nurses participate knowingly / unknowingly in the process and how it could be changed to improve their, and their patients', quality of life. Over the last ten years governments in Canada, the United States and other developed countries increasingly moved toward neo-liberal politics. Discourses emerged about the necessity of deficit reduction as major cuts were made to social services. As a result a variety of organizational changes, commonly referred to as 'restructuring' or 're-engineering', took place in the healthcare system. There were major impacts as many beds were closed and patient care services became greatly reduced. In the process a considerable number of nursing positions were eliminated and often substituted with those of unskilled labour.

I, like many others, am convinced that the access to skilled nursing services is the major reason why patients are hospitalized. The changes supposedly were introduced not only to reduce costs but primarily to improve healthcare. Yet during the restructuring process many nurses lost their positions and had to find new jobs, either within the same institution or elsewhere. Now there is an actual nursing shortage as a result. The quality of patient care seems to be constantly decreasing, as many recent newspaper stories report. The nurses who are still in the workforce are also deeply affected. As patients increasingly suffer neglect and are unable to access needed help, nurses are becoming more and more disillusioned with their jobs. Their workloads have increased significantly and amongst them burn-out due to stress is prevalent. Despite the fact that nurses represent the largest healthcare occupation and, along with their patients, are taking the brunt of the cut-backs, it seems they had little input into the changes. Overall it appears that healthcare, far from improving, has deteriorated substantially. Initially this situation led me to ask

the following question: How was it possible that, within the system that is supposed to keep people healthy, changes could be made which are detrimental to the health of patients and frontline workers?

My own interest and involvement in nursing issues goes back a long way. It started when I became a nurse in the early 1970s. I had not thought much about nursing before going into training and had chosen this career mostly for practical reasons. As a young woman and new immigrant I had just been laid off from my well-paying, yet boring, technical job in the electronics field, which I had held for a year. At this point I decided that I wanted to do something more with my life. As I was here in Canada on my own without family support, I did not have the means to stay in school for a long time. Nursing had just reduced its training from three to two years, after which time successful students graduated with a diploma. As I had always wanted to work with people I decided to apply and was accepted into a school of nursing at a local hospital. The more I learned about nursing, the more I loved it. Like the majority of nurses I meet, I found it 'amazing'. After graduation I worked for twenty-five years, mainly as a 'float' nurse in a city hospital. This meant I went anywhere I was needed, most of the time to special departments. Over the years with changing family responsibilities -- during this time I got married, raised two children and later divorced -- I switched between full and part-time positions, worked permanent nights for seven years and later permanent days.

As I floated my nursing experiences were very diverse. In the process I learned how nurses practice in many different roles within institutions. In the middle 1980s I went back to school and completed my baccalaureate degree in nursing, while continuing to work part-time at the hospital. After graduation I began teaching at the diploma schools of nursing in two local community colleges and a year later at an university in the nursing degree program. I am still employed as an instructor at the same university at this time. I also completed a Master's program and then went on to work on my doctorate (Ed.D.) in Sociology in Education, for which this research study is my doctoral thesis. Until three years ago I continued to work casually at the hospital. However, as I became too busy with teaching and academic studies I finally gave it up. Working with students I am still very much involved with nursing practice; through them and friends who are nurses I hear a lot about what is going on 'out there'.

The overriding issue, that I kept wondering about all those years, was why is it that nursing receives so little societal recognition? I know from an insider's perspective -- and all nurses seem to agree on this point -- how important good nursing care is for the well-being of patients. Therefore my greatest disappointment has been that it is largely unrecognized by others. The recent events clearly indicate that nurses are thought of as being disposable and easily replaceable with minimally skilled labour. I thought it important to find out more about the mechanisms that make it possible for nurses, as members of the largest healthcare occupation so essential to patients' health, to be treated as if they were unimportant and interchangeable. Why is it that society and the bureaucratic healthcare institutions do not seem to recognize nurses' services as valuable and essential, even though they represent the core of the healthcare system? I want to help elevate nursing into being recognized as the valued occupation it deserves to be, as I passionately believe that it can make an enormous difference to patients' recovery and well-being. I also know that nurses could contribute so much more than they are able to at this time, due to the many constraints that are inherent in the organization of healthcare as well as their own internalized perceptions about themselves and their work. Therefore, in this study I decided to examine what makes it possible for nursing to be devalued? What allows the decision makers in institutions to treat nurses as expenses to be cut, instead of as professionals who are providing services that are essential to people's health? What roles are nurses themselves, as active participants, playing in this process? I also wanted to explore, together with practicing nurses, possibilities to bring about desired changes.

### **Background of the Project**

In our healthcare system nurses work with people, sick and well, in a variety of settings and life situations. There are commonalities as well as diversities in what they do in the course of their work. How individuals and groups see themselves and their practice is rooted in the societal context. The perceptions we all hold are constructed through experiences and relationships with others. In Western societies 'male qualities', such as are applied in the physician's work of 'curing', tend to be highly valued. Physicians seemingly play the leading roles in the heroic efforts of saving lives and conquering diseases that the media are fond of reporting. As a result of

their high profile physicians' work receives lots of support from technological and pharmacological industries, as well as the state. They are also well-positioned within the existing legal and bureaucratic systems. 'Female qualities', on the other hand, like those inherent in caring, tend to be devalued (Baines, Evans & Neysmith, 1991; Davies, 1995; Reverby, 1987; Street, 1993). Such qualities impact more quietly on the intimate relationships and issues nurses deal with, making a difference in the private lives of people, often in times of crisis. As these relationships are diverse and unique in all situations, the proofs of their positive effects mostly rely on subjective reports. The outcomes are hard to generalize and measure objectively and therefore tend to remain out of the public view, as they rarely receive funding. The lack of official recognition, in turn, has an impact on the nurses' own and others' perceptions of the work they do and contributes in formulating their nursing identities.

To learn more about the various factors that impact on their practice and roles I decided to explore how staff nurses perceive themselves, their status within the multi-disciplinary health care team, and their relationships with groups they encounter in their work. Of course the context needs to be considered, as it has a major influence on how their work is carried out as well as how they and others perceive their roles. The institutional changes, precipitated by the official discourses and complex interactions in many areas, take on specific forms at the local levels. It is at these points that discourses get transformed into actions (Foucault, 1982) and directly affect the lives of patients and the employees of the health care system, including nurses. I therefore believed that the nurses' perspectives on how restructuring impacts on themselves and their work would be a good starting point. I also would ask them about their own ideas on how they thought restructuring should be carried out and eventually add their suggestions to the existing discourses.

Current occurrences always have ties with those from before. Discourses and events from the past form the basis for, and interconnect with, the discourses and events of the present (Foucault, 1982). Therefore, to better understand the current situation, the historical influences that shaped nursing need also to be taken into consideration. Knowledge about an occupation is transmitted to its members, down the generations, primarily through the educational system and the work environments. These institutions are the official sites where nurses are socialized into

their occupational roles. There they learn about their nursing duties, identities and appropriate occupational conduct. The rules of their conduct, in turn, are developed and enforced within their official regulating bodies. However occupational institutions do not exist in a vacuum.

Throughout the social body, word of mouth, the various media and the arts -- the whole cultural landscape -- perpetuate and help reshape occupational images less formally, therefore more insidiously. Through what is said and tacitly implied, selected knowledge becomes 'common sense', obvious and taken for granted by all members of society. In this way nursing, including what nurses do and how they are perceived in their roles, is shaped as a social construct.

However, despite these shared socialization processes and perceptions nurses are far from being all alike, to which any patient can attest. As individuals, nurses also vary in their perceptions about themselves and what nursing means. These perceptions impact on how they practice as well as on how they are perceived / received by others. Due to their individual differences the membership of occupational groups is never homogeneous. In addition work site characteristics of all disciplines vary from place to place. Recently Acker (1999a;b), who studied differences between two British school environments, refers to this phenomenon as 'institutional or workplace culture'. She, along with Chambon (1999) in Social Work, Dehli (1995; 1996) in Ontario's school systems and Nestel (2000) in midwifery, discusses how a complex multiplicity of factors shape work places along with the actors who work there.

Why some of the disciplines are more recognized and rewarded than others -- such as medicine over nursing -- is due to complex power mechanisms at play. The discourses in circulation determine the value of a discipline's work. The modes in which the disciplines carry out their work, arise out of and impact / are impacted by a multiplicity of elements. Therefore, to analyze the various power mechanisms, Foucault (1982) suggested we begin by studying the specific practices that take place at the local levels. Although I am aware of nursing's many roles, I focused on bedside nurses who work in hospital settings. I have chosen the hospital setting, first because it continues to be the place where the majority of nurses are employed, although this pattern is changing. According to Ward (1998), a researcher / analyst with the College of Nurses of Ontario, the 1997 statistics showed that approximately 60% of nurses work in acute care hospitals. Ten years earlier the figure was 80%. Second, although restructuring has occurred in

all areas of health care, the hospitals have been hit the hardest; hospital nurses can therefore be considered as 'exemplary' in experiencing its effects. In addition, most people think of the bedside nurse tending the sick as embodying what a nurse is and does. Another reason for my choice was that, as a former hospital nurse, I am most familiar with this setting.

Nursing as an occupation, particularly in hospital settings, operates largely as a hierarchy. There is much written and talked about nursing leaders' views of nursing and their visions of change in regards to its future. Historically since Nightingale's time an elite of nursing leaders fought for and determined the course of nursing, a practice that seems largely to continue. Decisions traditionally are made at the top, often without attention to or understanding of their effects on the practitioners at the bedside, for them rather than with them. Bedside nurses work in what Street (1993) describes as the 'swampy lowlands of nursing'. Therefore they are not only ignored by administration during occupational and institutional restructuring of care delivery, but also have little input into the plans that their own elite leaders envision and impose. They have to struggle with the everyday issues of the work place and with the policies and procedures imposed on them, which they often perceive as unconnected to their everyday reality and impractical for carrying out their work effectively.

In turn the practicing nurses tend to see themselves as 'passive victims' of events around them. They frequently also resist and ignore the directives as much as possible, which leaves their well-meaning leaders frustrated. The two groups' mutual disregard and lack of understanding results in intra-occupational tensions and divisions (Ashley, 1976; 1997; Daiski, 1994; Davies, 1995; McPherson, 1996). It also contributes to the continued devaluation of the occupation. The resulting lack of cohesion translates into a lack of political strength that a more united membership of this largest group of health care workers could exert.

In my own experience over the years I found that many nurses quietly develop ways to incorporate into their routines what they see as important nursing work, mainly the fostering of caring relationships that take place out of the limelight. These practices can not be expressed well within the protocols used in the system, as we will see. Therefore the actual nursing is carried out largely unnoticed, unrecorded and remains officially unrecognized. I believe it is time to pay attention to the perspectives of the individuals at the frontline, who have first-hand knowledge

about what goes on there and how they practice. To bring about effective improvements in the healthcare system I feel it is extremely important to listen to them. We also need to explore the past and present contexts, such as administrative discourses and actions, that set the stage for what goes on, to make the familiar visible (Chambon, 1999).

In this next section, I will give a brief overview of some current trends in the healthcare system in order to further elaborate on the context in which the study took place. This description is based largely in my own experiences and observations, the reports of practicing nurses I interact with, readings of professional materials and media reports.

### **Current Trends in Healthcare**

There can be no doubt that nursing makes an important contribution to healthcare within all areas of society. From the highly technical hospital intensive care units to people's homes and communities, nurses are expected to provide a humanitarian service, which aims to help others improve their health and thereby their quality of life. Instead of focusing on a person's diseased parts or problems, as is the case with other health care workers, nurses are concerned with the whole person. In order to provide good nursing care they need to pay full attention to his/her particular situation. In the context of their work they form relationships with people as human beings. Yet the beneficial effects of nursing care are often subsumed under and attributed to medical care. The view that nurses' contributions are largely undervalued by other health care professionals and the public is widely supported in the literature by Ashley (1976;1997), Benner & Wrubel (1988), Daiski (1994), Davies (1995), Doering (1992), Ehrenreich & English (1973), Gordon (1997), McPherson (1996), Valentine (1992) will be further explored in this project. The lack of public appreciation for nurses manifests itself in the erosion and elimination of nursing jobs in the wake of recent cutbacks in the health care system. In official rhetoric we hear about a 'healthcare crisis' (according to Ashley the present crisis started back in the 1970s; the history of modern nursing contained a succession of a variety of crises), as well as a search for improved, more efficient quality care.

Greenglass and Burke (1998) discuss how here in Ontario -- but it is also happening all over Canada in a similar fashion -- beds and even whole hospitals are closed in the name of 're-

engineering' and 'restructuring' of the health care system. The result is that altogether fewer jobs remain. There is also a trend to use 'cheaper' labour and/or pay educated employees, like Registered Nurses (RNs), less for their services (Peterson & Lupton, 1996). Increasingly nurses are replaced by lower-skilled or minimally trained individuals. In some hospitals so-called 'multi-purpose' or 'generic' workers might be dispatched, as needed, to anywhere from the kitchen department to the bedside, to administer direct patient-care formerly performed by nurses. Far from being new this practice has historical precedents as we shall see. Since these workers are 'unregulated' their training may range from several days to several weeks, at the employers' discretion. Another recent phenomenon is the 'casualization of nursing' (Fletcher, 2000a; Greenglass & Burke, 2000). RNs, who previously worked full-time and were laid-off, are frequently hired back as casual part-time employees with few benefits, much lower pay rates and no guarantees of how much work they will get. Some are even pushed into lower job categories as the only available employment, such as Registered Practical Nurses (RPNs) or sometimes nurses' aides. In these positions they still perform many functions that were part of their previous roles as RNs, but for less pay. According to the College of Nurses they can be legally held accountable to the standards of an RN. In addition, they are required to perform the relatively menial tasks entailed in the lower-paid job category. Overall there is a trend to pay less for healthcare services. Restructuring therefore seems to be more about fiscal savings than improved healthcare, despite official rhetoric to the contrary.

As part-time instructor at a local university I mostly teach students who previously graduated from a diploma school of nursing. These nurses are returning to school, usually while working, to earn a baccalaureate degree. In recent years, when talking to these nurses, I began to sense a pervasive helplessness and insecurity. They seem bewildered, demoralized and increasingly disillusioned. Many are directly affected within restructuring by losing their jobs or being forced to change them. All are touched by the changes indirectly by having to deal with increasing workloads, as well as stress and psychological pain over the dismissal of their co-workers, what is commonly termed the 'lay-off survivor syndrome'. It often leaves the remaining staff with a sense of guilt, as they were spared, while others lost their jobs. Current newspaper and journal articles frequently attest to burn-out amongst the nursing staff (Fletcher, 2000a;



Greenglass & Burke, 2000; Picard, 2000; 2001a;b). The outcome is a constantly diminishing quality of their working conditions, which endangers not only the nurses' own, but also their patients' safety and well-being.

The effects of restructuring are felt at all levels of society as hospital based healthcare in particular underwent a major downsizing. As, until now, the funding shift toward community agencies has not occurred as promised, the trend towards 'community based care' places the responsibility for caregiving largely onto the patients' families (Neysmith, 1991). There are also increasing signs of privatization, especially in the community, as only hospital and physician services are protected by the Canada Health Act. The more healthcare shifts towards the community, the more privatization of the services not covered by medicare can therefore be implemented. The people who have additional insurances or are able to pay out of pocket are hardly worse off. Amongst the less fortunate, however, these changes affect mainly the female family members. As wives, daughters and mothers they are the traditional, non-professional caregivers who therefore bear the brunt of providing these unpaid services. To obtain fiscal savings by reducing healthcare costs 'restructuring', it seems, is played out mainly on the backs of certain groups of women, be it the predominantly female nurses and other healthcare workers or the unpaid caregivers to the poor (Glazer, 1988; Neysmith, 1991). However, with long waiting lists and back-ups for treatments -- and lately frequent unavailability of emergency services -- it is now beginning adversely to affect even the middle classes.

The above described trends can be seen as a 'deskilling' of nurses' work, leading towards ever greater devaluation of the occupation. However, currently there is also a movement toward increasing education and specialization, which adds status to some nurses' positions. Nurse practitioners (N.P.s) in Canada hold at least a baccalaureate degree and receive additional specialized training to do some of the physicians' work. In October 1997, despite widespread protests by the medical profession, their practices became legalized in Ontario. There are also increasing demands for Clinical Nurse specialists who earned a Master's degree in nursing. Many of them occupy key positions to provide leadership within the healthcare team. Most nursing jobs in clinical areas require now some additional credentials like a specialization certificate. It seems that another offshoot of 'restructuring' is a further stratification of the staff who perform nursing

services, with a range from specialized knowledge encroaching on the traditional physician's role to minimal training. What this means for the regular bedside nurses' status and practice will be explored later.

Bellaby & Oribabor (1977) and Larson (1977) described two main strategies for occupational groups to protect their interests: one is the formation of professional associations, the other unionization. Even though professionalization historically and currently seemed to be the strategy favoured by nursing leaders, since the 1970s, more so in Canada than the United States, many nurses particularly those working in hospitals, had become unionized. Nurses' [visible] work, according to Bellaby and Oribabor (1977) resembled at the time more 'skilled work and craftsmanship' than a profession. As sociologists they were standing outside the occupation. They, along with Derber (1983), interpreted the stringent externally imposed regulations they observed as increasing trends toward 'proletarianization'. However, as nursing involves interactions with human beings rather than objects it provides for a high level of work fulfilment. Bellaby and Oribabor (1977) noted that, despite the 'proletarian' organization of their work, nurses seemed to experience low levels of 'alienation'. They found that not only the nursing elite, but most bedside nurses too, viewed themselves as 'professionals' in some sense. At the time, there was often widespread resistance to the emerging unionization movement, even amongst the rank-and-file nurses. This reluctance to organize had also been confirmed in my own previous study about twenty years later. Half of my participants then felt they, as 'professionals', should be 'above a self-serving blue-collar worker mentality' (Daiki, 1994). Therefore, in the past, unionization strategies resulted in division rather than unification amongst the members of the occupation. At the present time, however, trends towards greater militancy, as well as solidarity, seem to emerge as over the past few years a number of job actions by unionized nursing groups have taken place in several Canadian provinces (Fletcher, 2000a;b).

Recognizing that nursing neither fitted into a proletarian category, nor was it a full profession, many scholars (Cohen, 1981; Larson 1977; McPherson, 1996; Witz, 1992) categorized nursing as a 'semi-profession'. This classification signified the occupation's lack of the customary control over its own affairs, which is considered one of the hallmarks of 'professionalism' and which has historically evolved, as we will see. More recently Ashley

(1997, p.125) talks about nurses being educated as professionals, yet “they are in practice settings employed and treated as mere workers”. Many nursing leaders continue to strive for nursing to become a full profession; yet this designation is seldom defined or even questioned regarding its fit. Currently the academic nursing leadership in Ontario is engaged in directing the future of the occupation. Recently legislation was passed that makes the baccalaureate degree a requirement for entry to practice by the year 2005. As in most other provinces, actions are therefore being taken by ‘collaborating consortia’ of universities and community colleges to phase out the existing diploma programs and affiliate the colleges with universities as degree granting facilities. The parties involved are aiming to thereby legitimize a professional status for nursing.

However, this plan has met with resistance from unions, e.g. the Ontario Nurses’ Association (ONA). There are worries about job losses which may result from the sudden lack of qualification of the nurses now in the system, as the large majority of them hold a diploma education. Recently this concern materialized at a local non-unionized hospital. After some changes in the job qualifications a group of experienced RNs with diplomas, who were also high on the pay-scale, were laid-off. Meanwhile brand new graduates holding degrees, but lacking experience, were employed to replace them. As there is usually no financial reward for degree preparation, or a token one at best, hiring new nurses at an entry level also resulted in substantial savings for the institution. Therefore the danger exists that hospitals might capitalize on nursing’s eagerness to use education as a strategy to elevate its own status, by ‘colonizing’ (Foucault, 1982) the professionalization discourse with their own agendas.

The appeal to nurses’ ‘professionalism’, in my experience frequently used by management for their own ends, can be explained as ‘productive forces of power’ (Foucault, 1982). Existing discourses thereby get appropriated, transformed and used in varying ways by different parties, for their own purpose. For example, nurses are often forced to put up with impossible working conditions, e.g. high patient workloads due to understaffing, lest they face disciplinary actions for ‘abandonment of their patients’. ‘Prioritize and cope’ were words I was indoctrinated with in Nursing School and which were constantly preached to me in my working life as a hospital nurse. Whatever happened seemed to be my problem and it was therefore expected of me, as a ‘professional’ using the appropriate organizational steps, to solve it.

Nurses are not the only ones that are coaxed and coerced into producing work beyond the call of duty by appeals to their 'professionalism'. Along the same lines Acker (1999a;b), Apple (1986), and Dehli (1995; 1996), discussing teachers' work lives, point out that 'professionalism' is often used to manipulate this occupational group. Like nurses, teachers provide a public service which involves a 'nurturing' role. Like nurses, they belong to an overwhelmingly 'female' profession -- or are at least thought of as such -- and more so in the elementary grades. They too work in a bureaucratized setting, the educational system and, as they are mostly regulated from the outside, have little input into their work. They too are increasingly urged by governments and managements through appeals to their 'professionalism' to accept higher work loads or undesired work (Glazer, 1988; see also Dehli, 1995; 1996). It is also hardly a coincidence that they too have resorted to job actions in the last few years, as a new militancy of white collar workers seems to emerge.

Adkins and Lury (1999) discuss how today's professional workers are expected to be 'self-transforming subjects', who are self-governing by regular self-appraisal and performance reviews. Particularly men's conduct is regarded as 'work'. However, as far as women are concerned, their identities "may be naturalized as part of their selves, and can not be mobilized as a resource" (p.611). Rather than being recognized as work of self-transformation, their 'role performances' therefore are often viewed as part of the product or service they deliver, with 'caring' for others as an expected natural characteristic. Flight attendants and sales personnel are examples of such occupations. Hochschild (1983) describes at length how a "professional flight attendant is one who has completely accepted the rules of standardization" (p.103). In this particular occupation the company one works for demands complete control over the body, how one dresses, acts, feels. It means that emotional displays of smiles are part of the job descriptions, whereas personal feelings of anger or sadness are to be suppressed. Mills (1956) pointed to the extreme alienation of women workers in big department stores during the 50s. He discussed 'sales girls', wearing drab coloured clothes and expected to 'wait' on their clientele. They often came to hate their anonymous customers as the 'psychological enemies' instead of the store owner as their 'economic enemy' (p.174). The pictures of these groups are in many ways comparable to nursing's historical image (McPherson, 1996), symbolized by the white uniform

and a stern and proper demeanor. Hence it is important to remember that the concept of 'professionalism' is often used to further the organizational rather than the practitioners', or their clients', own interests (see also Chambon, 1999 on social workers). Nurses need to be aware and wary about this phenomenon of expected control of workers' emotions and disregard for their own needs as an indicator of 'professionalism'. This type of manipulation can be observed particularly where the membership consists largely of women, as in the groups discussed (Ashley, 1997; Davies, 1995; Glazer, 1988; Street, 1992).

Despite many changes much in the nursing world also remains the same. Previous influences linger on as taken-for-granted knowledge and continue to impact on nursing's identity. Like all other social constructs, this identity was not created and is not perpetuated and moulded in a vacuum, but articulates with all other societal relationships and events. Despite their leaders' visions, historically nurses had limited success in gaining control over their occupational destiny and influencing political decisions about healthcare. The traditional image of the nurse as handmaiden to the physician seems to persist (Aber & Hawkins, 1992; Kalisch & Kalisch, 1987), while the public remains ignorant about nurses' work (Ashley, 1997; Davies, 1995; Gordon, 1997). Add to this already confused picture the increasing trend towards the 'multi-disciplinary' approach to healthcare, which further blurs the roles of the various healthcare workers (Mitchell, 1999), and nursing's identity gets ever more obscured. The image of nursing was, and continues to be, shaped by nurses' experiences and interactions with other nurses, other health care occupations and the public they serve -- and all within the context of ongoing societal changes.

Heightened awareness about one's position within societal relations and forces is an important prerequisite before envisioning change. Within the confines of historical contexts and possibilities we can become conscious of 'what we do not want to be' (Foucault, 1982). Then we can imagine and choose from the forever newly emerging possibilities how we would like to change. I believe that nurses, with their focus on the whole patient, are best equipped to hold a central role within the healthcare occupations. They, better than anyone else, know their patients with their unique needs and situations, as they are with them more than any of the members from other occupations. They are best able to further the quality of their healthcare experiences and simultaneously derive work satisfaction from doing so. But currently they lack a strong voice,

and perhaps a shared vision, to make themselves 'heard' and recognized in order to take a more active part in the changes. By adding their ideas and exploring new possibilities, with them rather than for them, I hope to contribute to (re)valuing nursing.

Having provided this brief background of the project and current trends, in the next section I try to delineate the goals of the study more in detail.

### **Focus of the Project and Research Questions**

This study aims to shed light on the effects of restructuring on bedside nurses and their work at the local levels of hospitals. As this group of nurses seems to be most affected, I decided to explore their perceptions of nursing and its practice amidst the ongoing restructuring of the health care system. I feel it is important to add the accounts of their experiences to the discourses about restructuring. As the ultimate goal of this research is to better nurses' lives and those of their patients, with increased awareness I hope that productive strategies emerge that will improve healthcare. No doubt, the system could be / should be improved. However, changes, which are sensitive to the local context, effectively should be brought to voice and light from within. The devastating effects on the lives of patients and health care workers that are presently occurring must be reversed. That is the reason why the input from practitioners at the local level, where healthcare actually happens and where it can make a difference, is needed.

This study therefore explores how the current and past discourses on health care and events in the field impact on the images and practices of bedside nurses. I want to make visible how discourses change / maintain the existing power relations in which the nurses participate. As nursing is devalued in our society the goal is to discover strategies for valuing nursing and to ultimately improve current practices. By examining nurses' views on the events and their positions within the health care hierarchy, and relating them to historical traces and current discourses, I hope to make visible some of the processes through which their occupational images were and continue to be constructed. I want to increase understanding of how their perceived identities affect their actions / inactions and thereby contribute to the unfolding of restructuring as detrimental to their occupation. As players in the system they are inevitably caught up in the power relations of this process. Shedding light on how these relationships are

negotiated within their work environments will make visible alternative possibilities to bring about changes. Eventually I believe that other groups with related issues, particularly female dominated occupations such as teachers, flight attendants, social workers and 'sales girls', discussed earlier, will also benefit. Some of the insights gained here should also be meaningful for them as, most likely, there are comparable power mechanisms at work.

My conceptual framework for the study is based in Foucault's (1980; 1982; 1984; 1988) ideas on 'power' and 'subjectivity'. In most traditional analyses of power nursing is largely seen as 'powerless', whereas physicians and administrators are respected as 'powerful' professions within Western societies. The resulting polarization is not the most productive approach, as will be discussed later. Foucault saw power not only as a negative, prohibitive force -- the power to say 'no' -- as it is commonly understood. Society for him was not polarized into the powerful and the powerless, because short of a major upheaval, this conceptualization leaves little room for ongoing maneuvering. He viewed power as a largely positive force that circulates in society and is exercised within and through the 'veridical discourses', the discourses that are widely accepted as 'true' and therefore determine societal regulations. Truth for him was never universal but always negotiated. Power, from Foucault's perspective, exists in and forms all relationships which are inherently unequal, yet always also unstable, hence can be reversed at any moment. He saw power as circulating in the relationships of all players who are engaged in strategic games with each other, and working through local practices. Understood in this way it is largely a productive force: power constantly creates new opportunities for all participants involved, to bring about changes at their own local levels. Therefore I hope that Foucault's conceptualizations of 'power' and 'subjectivity' as the framework to guide the design and analysis of the research, will provide new insights.

The other important Foucauldian concept in this study is subjectivity. 'Subjectivity' refers to the formation and regulation of individuals through discursive practices. It is largely constructed through complex processes with roots in distant pasts that shape us into members of/within the larger society. Simultaneously we also belong to and are moulded and remoulded by the network of institutions such as families, religious and interest groups, and occupational or professional associations. These processes of identity formation rely on 'scientific' categories

and normalization mechanisms reproducing, producing, but also introducing variations and opposition to ways of being, mostly without our conscious awareness. Through them we learn to understand things as 'natural' and 'common sense'. However, for Foucault, some conscious awareness and deliberate 'self-styling' processes are possible. Active resistance to identities and expectations that are imposed on us, and that we disagree with, is therefore feasible. For analysis we best examine events that occur in relation to the societal context of the particular moment and its historical past. In order to expose specific strategies of power, Foucault suggested we focus especially on the 'acts of resistance' taking place at the 'local' level. Tracing what they are directed against should lead to the ruling 'discourses' and their 'truths' around which society is organized, and which the resisting individuals disagree with. From there 'counter discourses' can be developed.

To bring to light some of the mechanisms of power at play -- to get at the 'effects of power' -- from a Foucauldian perspective I had to begin at the local level. It meant going to the bedside, where the nurses work and where discourses get transformed into actions. In order to gain insight, consistent with Foucault's method, I particularly needed to focus on the 'points of resistance' in the everyday activities of nurses and to identify the discourses behind these mechanisms (Chambon, 1999; Chambon & Irving, 1999)). Once these hegemonic forces are recognized, individuals can develop counter strategies from within, at multiple local sites. The obvious 'points of resistance' are burn-out, nurses leaving their jobs and their talks about disillusionment with their work. How I used Foucault's ideas and method will be explained in more depth later in this thesis. I believe that this framework, concerned with the everyday world and focused on change at the local sites, will provide a useful fit for my project. The nurses' accounts of the restructuring processes and their effects at the bedside, I reason, will add an important piece of information that so far has been largely ignored.

The following research questions were on my mind at this point: What does the restructuring process look like at the bedside where it is transformed into actions? How do the changes impact on nurses' perceptions of themselves and the quality of their work lives? What are the nurses' perceptions of their own roles and of the relationships that they have with others in the system? How do nurses themselves participate, knowingly / unknowingly, in the relations



of power that bring about restructuring and shape their positions? What are the discourses behind the processes that reorganize institutional work and relationships? How do they impact on nurses' subjectivities and work lives? What are the participants' ideals of nursing? Which changes are accepted and embraced? Which ones are resisted and how? What strategies could be used to (re)value nursing? How could the nurses actively participate in bringing about changes that promote their patients' quality of life and their own quality of work life?

I was convinced that the nurses are the ones most knowledgeable to bring about effective changes. Therefore I needed a method of data collection that would get at the nurses' perspectives and stimulate them to reflect. For this purpose I chose a qualitative descriptive/ exploratory approach, using semi-structured interviews. This format allows for the participants to express freely their thoughts on the topics. My questions should provide them enough guidance to stay on the issues, yet allow them to diverge, to provide comprehensive accounts of the restructuring processes and their experiences and participation in them. I also would relate / compare practices and philosophies at the bedside to the current 'veridical discourses' of restructuring in literature and official documents. It would also be useful to examine how the discourses of the past continue to impact on present practices and perceptions, hence a historical review would shed some light on these processes. The data would then be interpreted within the conceptual framework of Foucault's ideas. I believe the method I chose provides increased insights into the nurses' own interpretations and desired changes about their 'received identities' and the situations forced on them. It brought to light some of the ways in which they, as active participants in their relationships with others, contribute to constructing their own images and practices that further or hinder the imposed changes.

As a former bedside nurse with considerable work experience in virtually all departments of a hospital I have my own perceptions of nursing, as well as of the institutional practices in which it takes place. During the interviews my own memories came back constantly, often about things I had long forgotten. The interviewees' tales triggered many 'flash backs' to my own experiences. I believe that to position myself up front is important in several ways: For one thing it will unavoidably colour my choice of framework, research design and questions, my own position and relationships vis a vis the participants and my interpretation and analysis of the data

(Ely, Anzul, Friedman, Garner & Steinmetz, 1991; Glesne & Peshkin, 1992; Mishler, 1986; Morse 1991). As I can not divorce myself from the process I believe it best to make visible my own stance. My life experiences helped shape who I am as a person, a nurse and a researcher, my own subjectivity, as well as how I constructed the interviews and data interpretation. My insider knowledge also has the potential for a deeper insight into the researched phenomena. Therefore, using myself as an 'instrument', I was striving to be conscious of my role and to act 'reflexively' as "part of, rather than separate from, the data and exploiting my self awareness as a source of insight" (Lipson, 1991, p.75).

### **Organization of the Project**

In this introductory chapter I described what led to the project, an overview of the project, the current trends in healthcare, the focus of the study and the research questions. In chapter two I take a closer look at nursing's roots, particularly its historical symbiotic relationship with medicine, that helped shape what nursing is today. The respective varying successes of these two groups in gaining status and control through 'professionalization' are explored. As we know, unlike medicine nursing was largely unsuccessful, particularly in achieving autonomy over its own affairs. Many of nursing's difficulties are better understood from within the historical context. It is, of course, also essential to examine some of the current -- often contradictory -- discourses that shape institutional philosophies, policies and procedures and to trace their influences on practices within the healthcare system. The present is examined from a macro level: a literature review on contemporary professionalism in nursing and related issues and discourses are discussed. A look at alternative views on and strategies of professionalism follows, that could prove more congruent with nursing's values. Although I draw on some of Foucault's work in this chapter, I found it useful to also discuss some of the other important literature on professionalization for my analysis. Many of the authors I refer to specifically talk about nursing's historical development and the impact of gender, while Foucault's work is generally more about discourses on medical knowledge.

In chapter three I describe in detail the conceptual framework that is based in Foucault's ideas on power and subjectivity. The chapter ends with a look at the local level: a discussion of

the contemporary dominant discourses that organize the work at the bedside. The methodology appropriate for this goal and how it was chosen is discussed in chapter four. There I further elaborate on the interview questions that flow from the research questions. The original plan, the process of selecting sites and interviewees, the journey of the study, difficulties encountered and the necessary modifications are told. How I came in the end to interview twenty bedside nurses from various city hospitals about their experiences is explained. A brief overview of the demographics of the participants and a general description of the sites is also included. It ends with an outline of the data analysis.

In the following three chapters the data are analyzed. Using Foucault's 'method' I discuss the nurses' accounts of the restructuring process and how it affects their everyday work lives. The chapters are organized in three layers. Chapter five, the most superficial layer, talks about the nurses' perceptions of the restructured work environment, the current trends in staffing and work patterns and how it should be done differently from their perspectives. Chapter six is about relationships nurses have with others in the system, their patients and other healthcare providers. It is based in Foucault's assumptions about power always being played out within unegalitarian, yet also unstable relationships between actors, with possibilities for change. Chapter seven, describing the deepest layer, is about nurses' ethical self formations. It discusses the nurses' ideals of nursing, their philosophies, their dissappointments, how their ideas have changed and where they believe nursing should go from here. It explores how they perceive themselves and how they believe others perceive them. I relate their statements to the historical roots of their practices and the restructuring discourses, those in the larger context of the socio-political arena, as they are expressed in the literature and the media. In the concluding chapter I attempt to tie together the various pieces of the thesis. After drawing some final conclusions I am looking at the implications of the findings for nurses themselves and their personal and collective strategies, administration regarding recruitment and retention, nursing education, what needs to change to help shape the nurse of the future, and lastly which areas would benefit from further exploration through research.

I will now start with a review of nursing's historical contexts. It will not be treated as a linear progression of events. Instead I will represent it "more as a window for locating our

present than for explicating the past" (Chambon & Irving, 1999, p.260).

## **CHAPTER 2**

### **HISTORICAL AND CONTEMPORARY CONTEXTS, THE OVERALL PICTURE**

#### **Introduction**

In this chapter I explore the historical development of medicine and nursing in the British and North American societies, in which our present Canadian healthcare system is rooted. These occupations are inextricably intertwined. I believe to get a better understanding of their current situations and relationships it is necessary to look at their embeddedness in Western historical developments. I review some of the literature about professions and professionalism, how these concepts originated and transformed over time. Nursing's and medicine's respective professionalization as well as proletarianization are discussed in light of social status, class and gender. Contemporary feminist views are explored for some new dimensions, particularly some alternative conceptualizations of 'profession', that could lead toward more desirable visions congruent with nursing values. Nursing's current discourses as portrayed in some of its literature are reviewed, as they too are part of the background for this study.

What follows does not claim to be a factual account of chronological events. Its purpose is to show the roots of the discourses that impact on nursing and its practice. The imperial history of nursing is the dominant influence on the development of the occupation in Canada, even though there are many other events that also contributed, like the immigration of nurses from different parts of the world. However, most of the nurses who trained elsewhere came from regions such as the Carribean that, under British rule, adopted a British education system. The point is, as Foucault suggested, that the present is inextricably linked to the past and that, by exploring historical contexts, we can shed light on many contemporary taken-for-granted assumptions and thereby rob them of their 'naturalness'. Medicine is one of the classical professions with a long tradition and will be discussed first.

#### **Professions as Status Groups**

The origins of professions, as we know them in the Western world, reach back to pre-industrial European societies. How they existed in the Middle Ages is often discussed in terms of

the Weberian concept of status groups (Elliott, 1970; Gidney & Millar, 1993, Mills, 1956). They emerged at a time when society was believed to possess a God given, natural order. Max Weber, in a posthumously published essay (Weber, 1958, p.192), described the organization of these groups: "The status order means...stratification in terms of honour and of styles of life peculiar to status groups as such". Weber's categorization was based on conceptualizations of professionals as 'ideal types'. Gerth and Mills (1958, p.59) saw 'ideal types' as "logically controlled and unambiguous conceptions, which are thus removed from historical reality...". Therefore 'ideal types' possess stylized 'traits' which result in stereotypical images of professionals and which are useful for examining their salient characteristics. However, it needs to be kept in mind that the resulting images are oversimplified. Then as now they did not account for the multiplicity of differences amongst professionals as real people and unique individuals, which we witness daily in our encounters with them.

Professional memberships in the Middle Ages in Europe consisted exclusively of gentlemen who held high social positions. European societies of that time were ordered by "hierarchy, stability and agrarianism and led by gentlemen rooted in the land" (Gidney & Millar, 1993, p.6). Notably men of lesser origins and women, regardless of their social status, were absent from the professions, since "scientia, the systematic bodies of knowledge, was the exclusive preserve of [educated] males" (p.8). Status then was ascribed by birthright, according to family position and inherited wealth, usually in the form of landed property. "Those with the highest status did not engage in work or have an occupation at all in the modern sense" (Elliott, 1970, p.15). Back then a gentleman was expected "to maintain a leisurely life style without manual labour and without engagement in commerce or trade" (p. 21), as the latter activities were considered of low status. Hence professional work then did not include any physical activity which, within the medical profession, left out surgery. Professionals were also prohibited from commercially advertising their services, a taboo that lingers on till today. Lately however it seems to weaken, as will be discussed later.

The 'classical' professions consisted of clergymen, physicians and lawyers. In all three occupations, professional men dealt with people's intimate and vital affairs: their souls, their health, their rights, and their properties -- the first three of these affairs are examples of what

Larson (1977) termed 'fictional commodities'. They are, to a large extent, in everyday life taken care of by individuals themselves, with aid of their families and social networks. Professional help is sought usually in only those cases that can not successfully be resolved by people in their own ways. Helman (1994) estimated that even today only about 20 per cent of illnesses are considered serious enough to warrant consulting a professional. Most minor ailments are either dealt with in the informal 'popular sector' by lay people, including the sufferers themselves, or improve on their own.

The professional's income was not perceived as derived from labour itself but was likened to the rents produced by ownership of the land. Reimbursement was obtained in the form of an 'honorarium', which was not considered as a compensation for services. Professionals did not work for pay. Instead, within the 'God given order' they were viewed as possessing moral integrity beyond reproach and therefore paid in order that they may work. This arrangement allowed for a high degree of freedom and discretion on their part. In return for their privileged position they had a "sacred duty, a commitment of service to others and to the larger social good" (Gidney & Millar, 1994, p.10). To safeguard standards, admission to professions was based on 'gentlemanly status criteria', which were deemed appropriate guarantees of the applicants' 'good characters' and intentions. According to Gidney and Millar (1993, p.12), these included that a gentleman was "regularly bred, regularly taught and regularly educated" hence "had the right educational and social credentials...to be trusted to exercise sound judgment, hold sound values and practice his craft according to the canons of reputable authorities and precedents". The word 'regular' denoted the 'normative' function of these credentials.

'Good character' was the overriding characteristic of a professional then. Knowledge was not yet specialized but generalized and represented a symbol of one's status position. It was also deeply embedded in "the prevailing religious Weltanschauung" (Elliott, 1970, p.19). At the time it was gained from schooling -- increasingly at universities -- in religion, classics and culture. It included the ancient languages of Latin and Greek, which had to be studied in order to qualify for admission into a profession. Knowledge specific to one's occupation was sparse and often more harmful than helpful (see: discussions of 'heroic medicine' by Ehrenreich & English, 1973 and Helman, 1994). Most knowledge was gained from books, not practice, as expertise in one's field

became an expectation only later on, during the nineteenth century. In the case of medicine if and how 'medical' knowledge and practical experiences were pursued was up to the individual physicians. For example they could attend a private medical school or "walk the wards in one of the voluntary hospitals" (Elliott, 1970, p.28) for this purpose.

In the Middle Ages, before the separation of religion and science occurred, the Church was the most influential societal institution. It played an important role as the 'gate keeper' of knowledge. There was no clear distinction between the worldly and religious spheres and the general population then was largely illiterate. Ehrenreich & English (1973) and Elliott (1970) discussed how the Church controlled access to most types of legitimate or formal knowledge and education. A symbiotic relationship resulted from the maintenance of strong links between the official educational institutions, particularly the universities, and the Church. Theology held a prominent place within all professional curricula. Even after society became increasingly secularized the Church of England remained closely involved in professional affairs. For example, in the case of physicians, "qualifications were denied to non-Anglicans" (p.19) even after the Reformation until the time when their own independent regulatory bodies were established and legitimized.

Healthcare, in addition to being practiced by the 'learned' profession of physicians, was also carried out by other groups of healers. In all cultures 'folk' healing practices are transmitted largely through the 'oral tradition'. In European societies at that time folk healers were of low status as they lacked privileged, recognized positions and education. They consisted mainly of women such as nurses and midwives who looked after the healthcare needs of the lower classes. Ehrenreich & English (1973) and Helman (1994) pointed out what many of the other writers, such as Elliott (1970), seemed to neglect: health care is practised widely within informal settings of family and community. Then, as now, ordinary people, particularly women, provided services and passed on their knowledge regarding herbal medicines and other healing methods to their successors. However, these types of 'healing' practices, then as now, remain largely undervalued, are frequently ridiculed or even outlawed, as the standards for healthcare practices are set by the professional physicians. As this particular group is perceived to be the most competent, its services and knowledge constitute the 'dominant discourse' (Foucault, 1982).



Then -- even more so than now -- any knowledge other than that of the professional status groups was considered to be extremely suspect by the official powers of State and Church. The concurrent devaluation of alternative knowledge and practices had far reaching impacts, particularly on women healers. During the Middle Ages they were not eligible for admission to formal schooling and therefore they could only exercise their skills in the lay sector. Yet, if a folk healer cured a sick person, after the learned professionals had failed to do so, s/he was accused of 'sorcery' and as possessing a 'pact with the devil'. "If a woman dare to cure without having studied she is a witch and must die...The witch craze provided a handy excuse for the doctor's failings in everyday practice" (Ehrenreich & English, 1973, p.19) and was a radical strategy to maintain their superior status in the field. It also had, no doubt, devastating effects on the transmission and expansion of alternative types of knowledge.

Alongside the physicians, amongst the male occupational healers, there existed two other groups, the surgeons and the apothecaries. In pre-industrial times surgeons had been denied access to universities and professional status, because the Church did not approve of the 'shedding of blood' in any form. This occupational group also engaged in 'manual labour' which was not in keeping with gentlemanly criteria of the time. Therefore they were forced to organize themselves separately from the physicians, along with the barbers and tradesmen, in the form of a craft guild. Of much lower status than professions, the guilds, as Elliott (1970) described them, were "associations of specialized workers...autonomous, but usually controlled by a specially recruited elite... that supervised training and recruitment and exercised some control over performance and practice" (p.24). Unlike their female counterparts it seems they were well tolerated practicing their trade and escaped persecution.

The late 18th and early 19th centuries brought about demographic changes through industrialization and urbanization, which slowly shaped the then existing societal structures into a capitalist system. 'Professional' physicians, numbering few, traditionally largely serviced the nobility and gentry. Apothecaries and surgeons increasingly looked after the health of the growing urban middle class and the poor. There was a huge surge in demand for services within these populations who, by leaving the countryside, were largely cut off from their traditional folk healers and kin. They now lived in the cities in overcrowded, unsanitary conditions. Due to rising

demands for services apothecaries and surgeons increasingly gained in status. They slowly began to bond with the professional physicians and to work towards their eventual integration with medicine.

At this time, according to Foucault (1973) a significant 'change' took place in how medical knowledge was organized, which transformed the profession. Even though, in antiquity, medicine had been taught at the patient's bedside, over time it had become based in philosophy rather than observation. After Hippocrates, medical knowledge was "organized into a systematic corpus...of knowledge that can be said to be, quite literally, blind since it has no gaze. This unseeing knowledge is at the source of illusion; a medicine haunted by metaphysics..." (p.56). Clinics, as a place to study and teach about human bodies and their diseases, had begun to reappear from the middle of the 17th century on. At this point though they still "symbolized rather than analyzed" (p.62) medical practice. In the last few years of the 19th century a radical shift in medical knowledge production occurred: "It was to be identified with the whole of medical experience" (p.62), as "a way of teaching and saying became a way of learning and seeing" (p.64). Instead of relying on theories, the 'gaze', thought to be 'pure' and unbiased, was now directed at the empirical manifestations of diseases in bodies dead and alive. The first scientific discourse concerning "man's being as object of positive knowledge" (p.197) had been created. The patient as 'subject' within this bio-medical model became 'invisible', as the 'gaze' was directed on his/her 'visible body' as the object that could be probed, invaded and empirically studied. The new method consisted of primarily focusing on the disease processes themselves that were intently observed and categorized. The base for Western medicine's successful approaches to 'scientification' had been laid, while the patient as whole person became a collection of functioning body systems and parts.

In 1858 the Medical Act in Britain recognized all the existing licensing and educational bodies of the occupations within the medical field. At that point in time, in medicine, "a single regulatory body had been established, embracing the old guild organizations and standing within the professions and the community and the state" (Elliott, 1970, p.39). Gradually a unified medical profession emerged, which included physicians, surgeons and apothecaries; the conventional professional structures had now successfully melded with those of the trade guilds

and the latter were thereby elevated into the ranks of the former. Strategically positioned in both the important institutions of universities and hospital, medical professionals were able to use their 'objective' knowledge, e.g. the scientific studies of anatomy and physiology, and somewhat later the 'germ' theory and discoveries of more effective medications, to bring about increasingly successful cures. The impact of these developments on the female practitioners of the healing occupations and other types of knowledge, who remained excluded, and the counter strategies they attempted is examined when I discuss the role of gender.

This type of 'new knowledge' provided doctors with progressively better means to meet the health needs of their patients. What represented essential knowledge for professionals began to be obtained through a specialized rather than the former general education. Separate medical schools linked to hospitals, as well as universities, began to develop and now included a practice component. Much of the pressure for a 'specialized' education had come from the professional members themselves. The guild of apothecaries had been the first group to move towards licencing through the institutions that provided their education. Following their lead, to assure standards, a system of registration slowly began to be used by all three groups "to assess expert knowledge and ability, not simply to ratify membership of a status group" (Elliott, 1970, p.39). Thereby they achieved autonomous regulation of their profession under state protection. As governments became increasingly secularized the Church had begun to lose some of its control. Gradually the professions therefore were able to shake off the Church's previous hold over their affairs.

### **Professions as a Social Class**

The developments discussed so far began in Europe and gradually spread to North America as its societies started to emerge from their pioneer and colonizing past. During the nineteenth century the professions, previously regarded as status groups, began to take on the characteristics of a privileged social class (Cohen, 1981; Freidson, 1971; Johnson, 1972; Larson, 1977; McPherson, 1996). Weber (1958, pp.182,3) described a "class situation" ultimately as "always a market situation...the factor that creates 'class' is unambiguously economic interest, and indeed only those interests involved in the existence of the market". As the emerging

capitalist societies reorganized according to market principles, professions managed to avoid the unlimited competition of the 'open market'. Instead their increasingly specialized knowledge base allowed professionals to create and service an 'exclusive market' under monopoly-like conditions (Larson, 1977). Beletz (1990, p.17) stated that as 'specialized knowledge' became the primary distinguishing difference between professionals and non-professionals, "the spectrum of influence of professionals has been narrowed to expertise and competence within their specific sphere". Shudson (1977, p.215) called modern professions "elites based on knowledge, a new type of aristocracy".

The feudal notion of 'noblesse oblige', the assumption that "a high social rank conferred rights but also imposed duties" had laid the groundwork for medicine's elite status (Larson, 1977, p.223). Nursing, and other female occupations, were historically disadvantaged in this regard. As women had no independent legal status they were unable to access universities. The former societal order, built on stratification in terms of honour and of styles of life peculiar to status groups, was now replaced by the pursuit of economic interests which had previously been deemed to be only low status activities. According to Weber's description cited above professions therefore could be categorized as a class. However many of the earlier notions in terms of elevated societal positions and privilege continued to linger on. To this day the 'classical' professions in particular are considered of 'high status'. They receive much respect and hold political influence in our society while open discussion about pursuit of economic interests still sits uncomfortably with professionalism in the eyes of many. The frequently voiced criticisms in the media of the high earnings of many doctors -- particularly specialists -- especially amidst the recent cutbacks in healthcare, speak of this widespread unease.

The professions increasingly began to regulate their membership by setting standards of performance. To attain control over their own affairs it had been necessary to move away from the Church's longstanding stronghold over knowledge and education, which had previously rendered it the gatekeeper of professional membership. In the process professionals, their knowledge now based in contemporary, worldly science, began to take over many functions that were formerly considered to belong to the realm of religion. This seems to hold particularly true for the medical profession. With the developments in the natural sciences "technology supplanted

religion". Patients began to view medical treatments as the "prime solution to [a] crisis in life" (Bellaby & Oribabor, 1977, p.805). This theme was also taken up by Foucault (1982; 1973) who saw 'salvation' increasingly as a goal to be achieved in 'this world', rather than the 'next', and through the new science of population health, as will be discussed later.

In the formative, precapitalist period no common standards for physicians had existed. Recognizing the necessity to establish the superiority of their services over others, professionals increasingly clamoured for a more unified delivery. This goal made it necessary to control the practices of its own members. Elliott (1970) saw the establishment of standards of practice as one of the major forces that compelled professionals to form their own regulating associations. Standardization of services had to be connected with 'stable criteria' for evaluation. To ensure uniform adherence to this process, state support in the form of legislation and state-enforced penalties against unlicensed practitioners had to be obtained. Smith (1987, p.217) cautions that, along with being a guarantee of standards, the rigidly prescribed organization of professional knowledge also leads toward a "monopolization of control within a dominant class".

The principle of meritocracy in membership selection was thereby put into effect. It gives the apparent impression that everyone's chances are equal. However, a serious flaw in this assumption is that university access can never be the same for all societal members. Into the early twentieth century it remained almost exclusively restricted to males of the privileged, wealthy classes and excluded women, as well as men of lower social origins. Equal access therefore largely applied to only the group of the already privileged. 'Scientific discourses' (Foucault, 1982) such as genetics theory, which viewed women as inferior to men and which also justified a type of 'social Darwinism' between all of society's members, helped legitimize these exclusionary processes. Today ever rising tuition fees are beginning to put university education out of the reach of many. A lengthy education requirement is thought to ensure competence. At the same time it acts as a gate keeping practice. It increasingly excludes not only those who do not possess the necessary cognitive abilities, but also those unable to afford the expensive preparation.

In addition the actual degree of difficulty to 'learn' and achieve professional competency, it seems, is not always commensurate with the length and intensity of the training required.

Frequently not all knowledge and skills acquired are later used in practice, e.g. a psychiatrist first has to become a medical doctor, dentists have extensive education in the natural sciences. Yet, in spite of both professions being highly specialized in their fields, they make practical use only of a portion of their vast knowledge base. The emphasis on and preoccupation with standardization has its own dangers. Millerson (1964, p.195) stated that there is a constant need “to maintain large-scale examinations, supervising institutions and adjusting syllabuses to meet changing needs”. He feared that these enormous tasks of bureaucratic administration, especially within large-scale associations, take away energy and resources from the primary purposes of the institutions, namely to educate. They tend to take on a life of their own. Today governments and employers increasingly pressure employees to continuously update their training. The call for knowledge to be standardized, particularly in nursing and teaching, puts these issues again in the forefront.

The project of ‘professionalization’ was paralleled by an expansion of services. The increasing demand for health care had led to the inclusion of surgeons and apothecaries, occupations of lesser origins, into an established pre-existing professional elite system. The accompanying redefinition of professionalism became possible when its standards, previously based on ‘gentlemanly characteristics’, were changed to incorporate criteria of craftsmanship and competency and medical knowledge became organized into an ‘objective science with classifications of diseases’ (Foucault, 1973). There also exists an institutionalized link between research and training. Both functions are located in the university and institutions where the profession is practiced, such as hospitals. Professionals therefore have the means to control their cognitive bases and memberships simultaneously, as the ‘production of knowledge’ and the ‘production of producers’ are unified within the same structures. These ties represent what Foucault (1982, p.792) described as, “the form of an apparatus closed in upon itself, with its specific *loci* [sic], its own regulations, its hierarchical structures which are carefully defined...a relative autonomy in its functioning... in a given social ensemble”. He saw large societal institutions as blocks of organized power with their discourses representing “the dark, but firm web of our experience” (Foucault, 1973, p.199).

Within their exclusive, specialized market, “professions were and are means of earning an

income on the basis of transacted services” (Larson, 1977, p.9). To make this exchange possible, “a distinct commodity had to be produced...a market had to be created...and the production of producers had to be controlled...State protection and the attitude of the state toward education and monopolies were a crucial element in the development of the professional project” (p.14). ‘Health’ and ‘healing’ are not tangible products, but what Larson referred to as ‘fictitious commodities’. They are not detachable from the rest of the person’s life and hence can not be produced for sale. Legal safeguards therefore need to be in place to protect vulnerable consumers; however, it is important to note that state involvement primarily also ensures that professionals could conduct their business unencumbered.

The field of health care seems to have an unlimited potential for expansion. Freidson (1986; 1971) described professions, under the cloak of their assumed ‘moral superiority’, as being ‘intrinsically imperialistic’, an orientation which serves their own interests well. As a result, in our society, ordinary life processes became increasingly ‘medicalized and pathologized’. Particularly, as the female body was a prime target from the start, childbearing and hormonal changes associated with the reproductive cycles and aging were incorporated as lucrative markets. The new frontier seems now to be men’s reproductive system, as the record numbers of prescriptions for Viagra have shown. Medicine’s progress was and is further fuelled by its ‘ideological’ dimension, which is based on the value of individual life that exists in Western society. Together with their hold over the natural sciences and accompanying technologies it helps ensure physicians’ privileged positions.

What is the difference between a mere occupation and a profession? Jackson (1970) stated that it is less a qualitative distinction than a ‘matter of degree’. Hence it is hard to pin down their salient features and their differences seem rather nebulous, even arbitrary. How close an occupation comes to the ‘ideal’ of a profession seems to depend, to a large extent, on how much control over their occupationally related activities is exercised by its members. It includes the ability to ‘mystify’ and to create a perception of moral superiority and importance. These are key issues leading to autonomous control over the labour process and membership. Historically they became well developed within the medical profession but have not been achieved in nursing. Effectively then as now professionalization perpetuates elite structures. The difference is

that these new membership criteria claimed to be based on the 'scientific discourses' (Foucault, 1982; 1980) of meritocracy and 'natural selection', whereas in the Middle Ages membership had been a 'birth right'.

Medicine's advantage clearly was solidified by its specialization within universities. Through the licensing system fitness for membership was established. Jackson (1970, p.10) pointed out that, in order to preserve exclusiveness, "the craft and the ideology and learning that go with [a profession] must be guarded from the uninitiated", making an element of 'mystification' necessary. In medicine's case, "the application of science to all areas of life constantly changed the cognitive bases" (Beletz, 1990, p.17), always producing "new knowledge". Because new knowledge in particular is restricted and controlled within exclusive educational institutions by a privileged few, monopoly is greatly facilitated and mystification is continuously reinforced. Therefore it is hard for the uninitiated to monitor a profession from the outside (Johnson, 1972; Larson, 1977). There is another important reason why external control was difficult to achieve, particularly in medicine's case. Consumers are often frightened by their experiences of illness that make them seek medical services. Lacking the necessary, specialized knowledge they are in a disadvantaged, vulnerable position. Therefore they are more willing to offer "uncritical acceptance" of medical authority (Larson, 1977, p.22). Public support tends to go to those practitioners who not necessarily are, but 'appear', more effective than others.

Achievement of the public's trust and recognition seem to be key to professionalization. Davies (1995, p.133), as well as Johnson (1972, p.33) and, more recently Johnson and Webber (2001), listed four main factors that they considered 'essentials' of professionalism. They represent a blend of the older criteria with the ones that had emerged later:

- 1) A high degree of generalized and systematic knowledge, which was increasingly obtained by a lengthy university education (exclusive knowledge).
- 2) A stated primary orientation to community rather than self-interest (altruism).
- 3) A high degree of self-control by professionals over their practice (autonomy).
- 4) A system of rewards both honorary and monetary (intrinsic and extrinsic).

Each of these characteristics will be further explored in the next section, in which I compare professionalization within medicine and nursing. They represent effective landmarks claimed by



medicine to hold its current place in society. Nursing, on the other hand, was only partially successful in their achievement.

### **Professionalism in Medicine and Nursing: Comparison and Critique**

#### **Exclusive knowledge**

A cognitive base that could be claimed as one's 'own' was one of the key strategic factors in the organizational effort of professionalization. During the 19th century, as exclusive knowledge and a specialized market emerged, the medical profession had successfully reorganized. With state support physicians were able to hold on to their customary power, status, resources and important influence on the public. The end effect was that "these characteristics favour a 'sellers' market', controlled by producers, based on the negotiation of cognitive exclusiveness" (Larson, 1977, p.25). Specialization had been achieved by medicine when it made the transition from status group to privileged social class. Since health care then as now was delivered by many types of healers, on formal and informal levels, medical practitioners had been successful "to clearly establish the superiority of one kind of service with regards to competing products" (Larson, 1977, p.14).

Having a hold over the natural sciences and accompanying positivist technologies through their ties with the institutions of both universities and public hospitals played an important role in physicians' domination of the health care arena. These institutions grew in tandem and worked together. Once credibility of surgeons and apothecaries was officially established the 'expanded' medical profession catered to the rich, including the urban middle class, while the 'lesser' occupations, such as midwives and nurses, or even so-called 'subnurses' served the poor (Ashley, 1997; Witz, 1992). By associating with elite clienteles the medical practitioners' status was further enhanced, while their less respected counterparts' lower status got equally reinforced. Nurses failed to create their own 'specialized market situations'. Their knowledge base and practice were diffused rather than focused (Davies, 1995). At the time medicine successfully adopted higher education as a means to acquire and transmit 'expert knowledge', establishing their own 'regime of truth'. Nurses, as members of a female occupation had, on the other hand, been denied access to formal education. They therefore had little choice

but to continue to rely on natural abilities, 'character traits' and apprenticeship training. They ended up becoming support personnel to the male dominated profession of medicine without a formally recognized knowledge base of their own.

### **Altruistic orientation**

Professing an altruistic orientation allowed professionals to claim 'moral superiority' and to discredit accusations of 'imperialism' in the name of self interests directed against them (see Freidson 1986; 1971.) Paradoxically, a claim of altruism simultaneously serves and protects the practitioner's own interests well, as it confers privileged social status with special rights and rewards. Professional institutions, autonomously regulated, oversee their own affairs, ostensibly to ensure the best interests of the populations they serve. To prevent abuse professional self control is to be safeguarded by a code of ethics, which becomes internalized by practitioners in the process of socialization and monitored through the voluntary association with other professional members. Through ongoing interactions with peers individuals acquire the norms and values of the group. These mechanisms are deemed necessary and effective to prevent the potential exploitation of the vulnerable groups they serve.

Members are recruited, selected and socialized into their professional roles under strict regulations of their conduct. Their own internal structures thereby become hierarchies of prestige, measured in peer esteem, and maintained through techniques of control (gate-keeping), surveillance (peer evaluations and reviews) and reproduction of labour (education and testing). The common overall goal is to provide services to others. Bellaby & Oribabor (1977, p.291), however, discussed professionalization as "a strategy adopted by an occupation to achieve collective upward mobility within the status hierarchy of the wider society". The ideological notion of a 'calling' to perform an altruistic service can also be a powerful element of social control exerted by the group that defines it over its own members. It tends to create conformity amongst practitioners and to identify people with their work roles, hence largely constructs their professional image.

The 'calling' concept serves thereby the important function of furthering the correspondence "between the public stereo typed expectations... and the aspects and behaviours

of the role players” (Larson, 1977, p.229), which certainly applies to both nursing and medicine. Millerson (1964, p.9) stated that “to achieve professional status, the occupation must be subjectively and objectively recognized as a profession”. A universal perception of the necessity and superiority of the services is therefore a crucial requirement. There lies however an inherent peril insofar as public trust in a group’s good will could be seen as sufficient guarantee for its moral integrity. As Larson (1977, p.243) pointed out, the danger is that ultimately power and privilege can become “automatic warrants of superior competence”. Altruism has served the medical professionals well, further enhancing their status. The same can hardly be said for nursing. Although nurses largely think of themselves as ‘professionals’ others do not recognize them as such. Society, knowing little about their work, perceives nurses as working under the physicians’ directions, following doctors’ orders. Their ‘feminine qualities’ render selfless dedication and self sacrifice more or less an automatic expectation (Adkins & Lury, 1999; Baines, Evans & Neysmith, 1991; Stewart, 1999). However, these qualities seem to be attributed more to their female nature, than ‘moral superiority’.

### **Autonomy**

The professional associations were organized and operated by the occupational members themselves, with little outside interference in their affairs, but with ‘state’ protection in the form of laws. This trend had first started in Britain and was taken up in North America, as the United States and Canada began to organize their civil societies. Thus professional men remained part of a ruling elite. Once the competition, which at the time included midwives and nurses, was effectively mitigated, medicine was able to develop its monopoly. As mentioned before, medical dominance was partly made possible through reliance on and incorporation of nurses’ labour into the medical work organization (Davies, 1995). Many of nursing’s difficulties, which prevented nurses from achieving full professional status, arose from their inability to control their own practices independently. This lack of autonomy led into their subordination to the medical professionals and hospital administrators. As a ‘paramedical occupation’ they began to exist in the shadows of these groups. Nurses became the ‘physician’s hands’ (Ashley, 1976; 1997).

Professionals, as the keepers of privileged knowledge, can act as “agents of power by

spreading the technocratic legitimization of domination and inequality” (Larson, 1977, p.224) which, in turn, “maximises the self-governance conceded to experts” (p.235). Johnson (1972) and Larson (1977) further discussed social control, as it is exercised by professions within their own memberships, where peer defined standards determine what members deem acceptable or unacceptable, and what counts as ‘excellence’. ‘Training’ happens through ‘hierarchical observation, normalizing judgement and their combination in a procedure that is specific to it, the examination” (Foucault, 1979, p.170). Paradoxically, as mentioned above, exclusionary practices tend to protect the professionals more than their clients. Specialization requires ‘inside knowledge’ to establish the ‘rules’ and monitor adherence and suitability to them; outside interference is therefore effectively thwarted. Nursing knowledge was never perceived as specialized but largely as based in natural abilities. Nurses were and still are viewed as paramedical staff. Working under the direction of physicians they use, to a large extent, the same knowledge base to carry out their work. Perceived as dependent on physicians and administrators they were largely externally regulated by these groups -- a legacy they are still trying to shake off, as will be discussed later.

### **Systems of rewards, then and now**

In earlier times professionals had been ‘paid so they may work’. Concurrent with the other changes however, they increasingly began to receive ‘fee-for-service’, which literally means they were now paid for their work. Recent polls show that about half of the Canadian physicians support at least partial privatization of health care, which would lead toward an American style open competition. These developments seem to indicate that an ideological shift from the noble ‘calling’ towards capitalist entrepreneurship is continuously taking place. At the same time the physicians’ traditional status largely persists. Their rewards, in terms of money and privileges, continue to be widely regarded as well-deserved symbols for work achievement. However, with increasing consumer awareness and unprecedented access to specialized, previously mystified knowledge via the internet, as well as a devolvement of responsibility for health towards individuals themselves, physicians today are beginning to lose some of their elevated status.

As discussed earlier, the notion of a 'work-ethic' in the form of an 'altruistic ideology' arose out of the ideals of professionalism and craftsmanship (Elliott, 1970). 'Intrinsic' rewards were to be found in the work itself, a condition likened to a 'vocation or calling' which had to fulfill a "civilizing function" (Larson, 1977, p.63), meaning it had to improve the lives of others. 'Intrinsic rewards' contrast with the less prestigious bourgeois entrepreneurial ideal based on extrinsic rewards, such as capital accumulation or sometimes salvation (see Weber, 1976). However, in the new capitalist societies, where money and possessions became the status symbols, physicians had successfully made the transformation towards extrinsic rewards. Today 'extrinsic' rewards, particularly monetary ones, are openly taking on greater importance, as physicians' recent strike actions and the ongoing negotiations around fees have shown. There are, it seems, some strong contradictions emerging in medicine around what counts as professionalism at this time. Nurses, on the other hand, to this day are expected to get satisfaction through self sacrifices and unselfishness; discussing the topic of monetary rewards still sits uncomfortably with many of them in my experience. Yet they too are changing their views as their recent job actions have shown (Fletcher, 2000a;b).

Freidson, in his own earlier writings, maintained that professionalization could become a potentially emancipatory counterforce to the ever-increasing 'managerial control' and 'rationalization' that organizes social life (see Freidson, 1971). More recently, however, Bellaby & Oribabor (1977, p.292) reported a general trend within professions, including medicine, toward 'proletarianization', whereby an "occupation is stripped of real ownership and its means of production and subordinated to capital". This view was also supported by Derber (1983), Larson (1977) and Mills (1956). In developed countries like England, Canada and the United States even doctors experience increasing pressures to work for salaries in hospitals and other health centres which are often privatized, such as Health Management Organizations (HMOs). An ever larger 'bureaucratization' subordinates them as employees to institutional employers, whose facilities and equipments they use, as opposed to their customary, independently owned practices. Many physicians in the United States work for HMOs, which are profit driven, and largely owned by private insurance companies. Despite a 'conflict of interest' some doctors are also share holders of these organizations. In the United States a two-tiered healthcare system with

a state and a private sector has always existed. In Ontario the King's Health Centre, which recently became defunct, was an example of a similarly organized institution, catering mostly to patients with private insurers as 'third-party payers' (Fuller, 1998, p.243). England too has now created a two-tiered health care system. Its main difference to that of the United States lies in the size of its private sector. In the United States the largest sector of health care operations is privatized, whereas in Britain the majority continues to be run by the state.

Increasing outside control, directed at physicians' professional autonomy, is also beginning to emerge. The recent attempts in several Canadian provinces, like Ontario and British Columbia, to geographically restrict first time practising doctors to rural or remote Northern areas are an example of this trend. So far these attempts have failed, as physicians fought back and won. They were less successful in protecting other areas of their work. Despite their protests, nurse practitioners are now taking over some of the functions that had been traditionally performed by medicine. Overall it seems that the privileged social class of professional physicians, which had arisen from pre-capitalist institutions, then passed through a phase of specialized markets, is now headed toward integration into the general capitalist market system based in privatization and competition. At the same time, losing some of their status might drive physicians toward a more egalitarian position with other healthcare providers, such as nurses (Fuller, 1998).

The next section will focus on nursing and the role gender played in its development. Even though low status male occupations, surgeons and barbers, achieved acceptance into the prestigious medical profession, the female healers had been unable to do so. Hence it seems that gender played a deciding role in their occupational development.

### **The Role of Gender: Nursing as a Feminine Professional Project**

Since antiquity, religious institutions, as well as the military, relegated care of the sick to men and women, often to match the gender of the cared for (Davis & Bartfay, 2001; Hamilton, 1996). In earlier Christianity nuns and monks played an important role in nursing, even though salvation of the soul probably took precedence over other health concerns at that time. This was in keeping with the lack of specialized medical knowledge and an other-worldly orientation then.

The 'gaze', splitting body and mind, had not been conceptualized yet and religion governed people's lives into the most intimate details. Medicine, right from the start, was considered one of the full professions and as such historically male-dominated and privileged. In contrast nursing developed into, and largely remains, a 'female' occupation. Women, as 'non-persons', did not have legal status of their own when the movements toward standardization and member registration began. Unlike physicians nurses therefore were unable to achieve autonomous control over their own affairs.

As a consequence some authors view the role of gender as the most important determining factor in achieving professional status (Ashley, 1976; Cohen, 1981; Davies, 1995; Ehrenreich & English, 1973; Marks & Beatty, 1972; McPherson, 1996; Witz, 1992). Their analyses are built on the assumption that we live in a 'gendered world'. When using this type of framework, I believe it is important to make a distinction between real women and men on the one hand, and 'masculinity' and 'femininity' on the other. Davies (1995, p.21) suggests that these latter concepts are "cultural codes or representations of gender and, that gender...pervades our earliest experiences and shapes our sense of identity". It thereby structures how we relate to each other, not only within our personal lives, but also in the public arena of work and politics. Similarly Connell (1987) sees 'gender' as an 'organizing principle' in society, yet he stresses that the global and local organizational patterns often differ. Heap (1999) describes the evolution of the 'Science of House keeping' in the Faculty of Household Science, into the 'Science of Nutrition and Dietetics', at the University of Toronto in the first part of the 20th century. It started out as a 'female project', natural to women. Over time it developed from relative invisibility as a woman's turf into 'food science in biology and chemistry', which led to an influx of men into the field. It thereby became increasingly masculinized, leading to the eventual closure of the Faculty of Household Science as a separate department in the late 1970s. Acker (1999b) warns that focusing on women to the exclusion of men, in areas such as teaching, will lead to a distorted picture. And Nestel (2000) shows in her exploration of the recent resurrection of midwifery as a respectable discipline in Ontario, how the focus on gender issues from a 'white feminist perspective' by its proponents led to 'blindness' towards other inequities, particularly regarding ethnicity, race and class.

Witz (1992) discusses the nineteenth century medical professional project in terms of a “male project and a form of patriarchal exclusion” (p.80). Medicine’s success, she states, was largely made possible with the help of the “patriarchal state as institutionalized male power... even though non-market domestic care was overwhelmingly provided by women”. The result was a ‘masculinization’ of the emerging professions, from which the female ‘healing’ occupations were officially excluded (Ehrenreich & English, 1973; Witz, 1992). As they remained shut out, and sometimes even prevented from legally pursuing their livelihoods, groups of female practitioners began to aspire towards their own professional status. In response to the ‘male’ professions, the historically less prestigious and more folkbased occupations of midwifery and nursing underwent a systematic ‘feminization’. In turn they started to exclude male practitioners and thereby became ‘naturalized’ as ‘female occupations’ (Davis & Bartfay, 2001). At the same time other groups of women continued to fight for and eventually began to achieve inclusion into the male professions. However, frequently the price they paid was to adopt ‘male standards’ and many began to distance themselves from, and in turn to oppress, other women in the lower status female occupations they worked with (Ehrenreich & English, 1973). Others began with typically ‘female’ interests, such as ‘household economics’, described above and developed over the years as a recognized and important academic subject recognized by both genders (Heap, 1999).

Nursing is often classified as a semi-profession. In contrast to professions, semi-professions are “occupations which are located within bureaucracies and in which women predominate” (Witz, 1992, p.60). They are characterized by more external control and thought to have a less exclusive knowledge base. Gaskell (1983) maintains that, although female occupations are generally viewed as needing less training and fewer cognitive abilities, “jobs in which women predominate require as much formal schooling and as much ‘cognitive complexity’ as the jobs in which men predominate” (p.13). Hence she sees the issue not as a lack of women’s skills but as a lack of reward for and recognition of their skills. Heap (1999) makes a similar argument. Because faculty and students in household economics originally were female they lacked the same recognition awarded to male dominated departments. Considering the historical as well as current situation this argument seems to hold true for nursing and secretarial



work, largely deemed to arise from natural female qualities. Teaching is often included here. However this issue is more complex as there are relatively more men in teaching, particularly in the higher grades (Acker, 1999b). The activities of the 'female' disciplines also mostly take place out of the public view. To make their work more visible Davies (1995) concludes that a distinction needs to be made between care giving as the unpaid caring performed by women in the home, and 'care work' as the professional caring performed in the public arena. This is also an issue that contemporary nurse theorists are aware of, as they are formalizing nursing as a science and an art through the development of nursing's own distinct body of knowledge.

For the reasons discussed before nurses were more likely to treat the poor, whereas the medical profession took care of nobility and the rich. In addition nursing had lost its respectability even more with the advent of Protestantism. This religious organization had no equivalent to monasteries and convents -- its believers viewed illness as resulting from a lack of divine grace -- hence as an embarrassment. In the secularized Protestant societies, tending the sick and dying outside the home was therefore performed by lay people of low status -- mainly women with often doubtful 'moral' reputations (Hamilton, 1996). Marks and Beatty (1972) discussed some of the rules that hospitals had imposed in the middle of the 19th century on their nursing staff. They forbade drunkenness, quarreling or brawling and decreed that "no dirt, rags, or bones may be thrown from the windows" (p.159). The poor quality of nursing at that time largely explains Nightingale's preoccupation with the 'moral character' of her nurses, as she tried to rehabilitate the occupation to become a respectable vocation. In societies that remained Catholic care of the sick and destitute continued to be largely practiced by religious orders and never reached the same low points. Eventually some of the protestant religious organizations became involved in nursing's rehabilitation, like the St. John's House in London in 1848 (Marks & Beatty, 1972).

Around the middle of the nineteenth century, after an unsuccessful attempt to join the male medical professions, some nurses began to launch their own 'female professional project' (Witz, 1992). They thereby aimed for licensing and registration. Under the leadership of Bedford-Fenwick in England, during the latter half of the nineteenth century, a group of nurses tried on their own to become independent professionals, similar to doctors. However, another

nursing leader at the time, Florence Nightingale, had very different ideas about what activities she considered appropriate for women. Of high social status herself, and in keeping with the proper image of a 'lady' in Victorian society, she perceived women to be dependent on men and in need of their protection. In her mind female respectability was incompatible with the role of autonomous professional and gender equality. According to Marks and Beatty (1972) she was indifferent to 'the rights and wrongs' of her own sex. However she "felt a burning anger at needless suffering" (p.161). They cited her maintaining that "nursing should not be a profession, it should be a *calling*" (p.174), emphasizing altruism over autonomy, even though both characteristics were typical of the classical professions. She was therefore opposed to the 'registration movement' which aimed for independent nursing practice, as she understood nursing as a learned occupation 'naturally' suited to women.

A Nightingale nurse "embodied the very spirit of femininity as defined by sexist Victorian society" (Ehrenreich & English, 1973, p.37). 'Good character' was emphasized over abilities and skills, criteria the medical profession had shed by then in favour of its specific body of knowledge and competence. Supervised by matrons, who themselves were members of the middle classes, the mainly working class women who comprised the nursing workforce were taught Victorian societal values and were required to live by them. Hence Nightingale's ideas about rehabilitating the nursing occupation resembled more a project of social reform of nurses than professionalization as it was sought after by Bedford-Fenwick and her followers. At the same time she organized nursing as a hierarchical system similar to the military model, in which the practicing bedside nurses learned docility and had to follow the orders of the matron, as well as those of the male physicians and administrators (Cohen, 1981; Falk-Rafael, 1996).

It seems that many influences from that time linger on to this day, especially the hierarchical structure of the occupation. Ultimately Nightingale's vision predominated in how nursing was rehabilitated into an organization suitable for women. Respectability was achieved at the cost of decision making and autonomous control in professional matters. "By entering the male and physician dominated institution of the hospital, nurses and nursing formed an alliance with the medical system"(Cohen, 1981, p.6). Derber (1983, p.318) describes this arrangement as a "Faustian Pact" and a form of "ideological proletarianization". Freidson (1971, p.802) observes

that “nursing became a subordinate part of the division of labour within [the hierarchy of] the medical profession”, by largely carrying out the work which its own practitioners considered undesirable. Thereby it became a ‘paramedical’ occupation, subordinated to medicine. Freidson further states that, in the societal context of the time, nurses’ collective aspirations for professionalism “bear a definite relation to and are in many ways vitiated by their subordinate position in this division of labour...Nurses, as handmaidens, gained status, which coincided with the social status of women at the time, subordinated to ‘male’ doctors and hospital administrators” (p.807).

It is easy to critique in hindsight. Yet, what appears to us now as obvious discrimination had a very different meaning then. As women at that time did not possess civil rights they were legally dependent on men. Unable to negotiate for themselves, they had to work, behind the scenes, through ‘male power’ -- husbands, fathers, brothers, and friends (Witz, 1992). Cohen (1981) states that Nightingale achieved her own goals through manipulating powerful men, while she remained in the background. Bedford-Fenwick too used this strategy. Since professions were originally defined in the framework of ‘male’ professionalism, Cohen (1981) states, the ‘masculine’ came to mean professional knowledge and competence, whereas the ‘feminine’ values, such as nurturance, were seen as ‘unprofessional’. Reason was, and continues to be, valued over emotion or what is associated with it. Even though the same standards that applied to the male professions also applied to the female occupations, in many respects they produced very different results. Like her ‘male’ professional counterparts had in the beginning, Nightingale envisioned nursing as based on ‘altruism’ and ‘intrinsic rewards’, “a dedicated calling, akin to religion with little importance attached to status and [external] reward” (Witz, 1992, p.131). I find it interesting that the notion of ‘calling’ for male professionals resulted in an elevated social status based on ‘moral superiority’. For females however, associated with what society at the time held as ‘womanly virtues’, ‘calling’ resulted in expectations of subservience and invisibility. This division, attributed to male/female characteristics, exemplifies the impact the construct of ‘gender’ has, as a ‘dividing practice’ (Foucault, 1982), which will be discussed in the next chapter.

According to Ashley (1997) nurses themselves have historically viewed self sacrifice for

and support of, not only patients, but also other groups in the health care field as 'morally right'. "Their economic exploitation and their subservient role have been universally accepted. Institutions and laws kept them in their powerless position" (p.40), due to the view of women and family held by the dominant bourgeoisie in Victorian society. Stuart (1993) describes "true womanhood" as based on four cardinal virtues: piety, purity, submission of self and domesticity. In keeping with this picture "the nurse was expected to be utterly pure, self sacrificing and good" (p.20). The physician, as the visible, knowledgeable, professional authority, was often likened to the 'father'. The nurse, working behind the scenes, caring for and nurturing doctors as well as patients, represented the 'mother'. Their dependent child, in need of 'cure' -- based on authoritative knowledge -- and 'care' -- based on womanly qualities -- was the patient. The 'hospital family' reflected the ideal of the Victorian family, a view on which our health care system became established (Ehrenreich & English, 1973).

In Victorian England the voluntary (publicly funded) hospitals "provided the institutional shell for the modernization and reform of nursing" (Witz, 1992, p.137). This arrangement with its on-the-job-training produced a "symbiotic relationship between hospitals and nursing labour" (p.166). Apprenticing nurses worked largely for free which led to widespread exploitation, a practice that particularly in the British system persisted to this day, as Davies (1995) reports. Nurses functioned under the authority and leadership of the medical professionals, carrying out their orders. Reverby (1987) identifies the silencing of the female voice in a world increasingly dominated by rational male values as the reason for nurses' difficult position. Paradoxically they were expected -- but not respected for doing it -- to work from the values of a feminine identity. Physicians and hospital administrators further expanded on Nightingale's assumptions about feminine qualities. They argued successfully that, due to 'natural' womanly virtues, a good nurse was 'born, not made'. Yet they ignored the other side of Nightingale's position that nursing was also a learned discipline. She herself had never greatly elaborated on this issue, as she left the running of the St. Thomas School of Nursing, once it was established, mainly in the hands of the first matron, Mrs. Wardroper. The result was that "nurses were to be trained while physicians were to be educated" (Doering, 1992, p.28). This arrangement also helped maintain the sharp division and hierarchy amongst the by now university 'educated' physicians and hospital

'trained' nurses.

It comes as no surprise that, along with Nightingale, hospital administrators were the main opponents to the 'registration' movement of nurses. When registration finally came about in the early twentieth century nurses, unlike their medical counterparts, were unable to obtain the same degree of institutional control. The state could annul or modify any rules since women were at that time still 'non-persons' without legal status on their own for roughly another ten years. In the countries discussed here they achieved legal status around the 1930s. In England, thanks to Nightingale's legacy, the schools of nursing had been endowed. Nurse educators in that country were therefore able to maintain some degree of autonomy and control at least over their curriculum. In North America however, where endowed schools were lacking, hospital employers, not the members of the occupation themselves, remained the gatekeepers for 'the production of producers as well as the production of knowledge', as they provided and controlled nurses' apprenticeship training. Due to the legacy of nineteenth century 'science' women were thought to be emotional and incapable of reason. Male supervision was thereby ideologically justified. According to Ashley (1997, p.124): "The logic has been that because nurses were women limitations and boundaries had to be placed on their behaviour and actions...our laws reflect more about our roles as women than... professionals", an illustration of how the personal is intricately intertwined with the public image. The various discourses about gender were ultimately responsible for the inability of nurses, and other female occupations, to attain autonomous professional status equal to the male professions.

Ashley (1997; 1976) claims that, until the Depression, North American nurses had little choice but to work in private practice. As hospitals on this continent were mostly staffed with unpaid students versus the paid labour of trained graduates, there were few institutional jobs for them after training. McPherson (1996) and Wagner (1980) however see private practice as much more desirable than institutional employment. They report that, unlike their British counterparts, who worked in a much more institutionalized system, graduate North American nurses had remained largely independent. McPherson (1996, p.14) likens the eventual employment by hospitals, into which nurses were forced by the increasing institutionalization of health care, to "driving the peasantry of the land in the 18th and 19th centuries". She, along with Bellaby and

Oribabor (1977), maintains that North American nurses who formerly were "independent producers" thereby became more like "skilled workers or tradesmen" and hence, like these groups, increasingly 'proletarianized' and subject to institutional bureaucratization. Today there is a new resurgence of entrepreneurialism (Hamilton, 1996) as many nurses, disenchanted with how they have been treated within the institutions, are trying to establish their own independent practices. At the university where I teach there is a new credit course regarding how nurses can set up their own practice.

Nightingale had created the nursing occupation after the hierarchical model of religious orders and the military. In light of its history this organization of labour must have seemed 'natural' at the time. The matron presided over and controlled the rank-and-file bedside nurses. Within their own professional projects nurses used the same exclusionary and controlling strategies as their male counterparts. Ashley (1997) and McPherson (1996) discuss how, due to this legacy, many practices in nursing effectively discriminated against those of lower status, women (and men) of different racial, ethnic and sometimes class origins. In Ontario Stuart (1999) describes the division in perceived status between public health nurses and those employed in hospitals, which translated into much more autonomous practice of the former. While hospital nurses received 'hands-on training', public health nurses were educated within the University of Toronto through a one-year certificate program. In Canada to this day (see Hardill, 1993) there are strong hierarchical formations in institutions with white Canadian born nurses as a female elite and representatives of other races / ethnicities mainly occupying the lower end jobs. In midwifery (Nestel, 2000), which recently became a university-educated professional discipline in Ontario, there exists an almost total exclusion of anybody other than white Canadian borne women. In the next section I will look at contemporary nursing that had arisen out of this historical context.

## Nursing Today

Occupational identities are transmitted in various ways through complex power mechanisms based in assumptions, traditions, values and beliefs. Connell (1987), as well as Davies (1995), see these mechanisms as deeply embedded in the 'gendered' organization of our societies, where the 'masculine' and the 'feminine' are constructed in binary opposition and treated as mutually exclusive. The image of the nurse as the 'self-denying mother' who went to the first world war for her country was exploited by various groups, such as "the Canadian Red Cross, the emerging welfare state, and contemporary nursing leaders, who all had reasons to enhance this imagery to further their own goals" (Stuart, 1999, p.171). She became the powerful figure who would save the world from barbarism. However, Stuart found that besides this romanticized, patriotic version there was another side: It involved adventure, travel and a good time, perhaps even an alternative to the constraints of marriage for some. Many nurses obtained esteemed public health nurse positions after the war was over. Today the image of the nurse still harks back to the vision of the feminine held at the time of the Nightingale reforms. Nursing continues to be widely perceived, even by some of its own leaders, as based on female 'character traits' (Chafey, Rhea, Shannon & Spencer, 1998) rather than on knowledge and responsibility. Kalisch & Kalisch (1987) conducted studies of the public's view of nurses in the 1980s. The authors found that the main ideological idea in the case of nursing remained the 'natural', gendered division of labour, which casts nursing as 'feminine' work. They maintain that, "the image of bedside care remains the cohesive element in the nurse's identity and it appears rooted in the conception of nursing as a self-subordinating, giving, nurturing, quintessentially feminine activity with the powerful residual appeal of the self-sacrificing angel" (p.3).

Aber and Hawkins (1992) performed a content analysis of advertisements appearing in health care journals. They found nurses were mostly portrayed as passive female 'sex objects and handmaidens', whereas doctors were almost always shown as male and active 'serious professionals'. Porter, Porter, and Lower (1989) recommend empowering nurses and improving communication to enhance nurses' self perceptions. MacPhail (1991, p.60) states that "although the image of nurses and nursing may be changing to overcome the 'sex object' image that still exists in the mass media, the challenge for nurses is to change both the internal and external

images of nursing to promote the 'careerist' image". She too believes that only nurses themselves can do it. Curtin (1996, p.322), on the other hand, claims that "the real problem isn't that nurses are portrayed as sex objects, but rather that nurses are portrayed as *nothing* but sex objects". Both authors refer to television shows in which nurses are usually shown as 'mindless bimbos' who never do anything but flirt and look pretty. They helplessly panic in emergencies, and usually their only action is to seek the help of a doctor. Physicians too, she feels, are portrayed as sex objects, yet they, unlike the nurses, are also competent and act autonomously. In recent years nurses' images in some of the shows are now improving. After much lobbying of the media by various nursing groups, 'ER' and 'Chicago Hope' depict nurses as competent and decisive, yet still subordinate to physicians.

Davies (1995, pp. 60, 61) maintains that the seeming 'autonomy' of physicians in reality "turns out to require considerable work by others and without this work it cannot be sustained...Nursing is the activity...that enables medicine to present itself as masculine/ rational and to gain power and privilege of so doing". The submissive and supportive role of nursing shoring up medical practice continues to this day, yet remains largely unrecognized for what it is. Mills (1956) discussed white-collar girls, the secretaries in his time who, like 'sharecroppers' who have no part of ownership in the land, worked for male bosses and propped them up. They did what was necessary that facilitated their bosses to succeed. In the process they seemed to substitute their careers for 'marriage'. Mills compared their climbing the stairs to the office to climbing the stairs of a nunnery, as they dedicated their lives to facilitate their bosses' careers.

Bellaby and Oribabor (1977, p.815) ascribe the public's perception of nurses to the "social organization of labour" within institutions. Nurses are seen as "functionary" rather than professionals. In hospitals they perform a series of tasks "not the total care process". In addition their "pretensions to professionalism are undermined by their inability to close nursing to untrained recruits". The mechanism that leads to the erosion of boundaries -- or prevents their establishment in the first place -- seems to be the easy breakdown of nurses' work into specialized tasks. While some types of specialization result in an increase in status (e.g. heart surgeons, neurologists, nurse practitioners, clinical nurse specialists), specialization in tasks, rated as 'technical performance', has led to deskilling for nurses. The difference is that



'professional specialization' is based on an exclusive knowledge base which, within our technocratic society, usually consists of some kind of 'scientific' technology. Specialization of tasks however which can easily be learned, facilitates 'proletarianization' and 'deskilling', when it is believed that these discreet actions can be performed successfully and much cheaper by minimally trained workers. Thereby work gets "assimilated to the broad working class under capitalist labour control" (Derber, 1983, p.335), from an exclusive market into the open market.

Ashley (1997) discusses the devaluation of nurses' work as it persisted throughout the twentieth century. She too believes it to be rooted in nurses' inability, unlike their medical counterparts, to create specialized markets. From the start "the open market concept applied in nursing where 'subnurses' were giving care to the poor, hence were encouraged to compete for jobs" (p.228). Subnurses, as minimally trained hospital employees, seemed to be the 'unregulated workers' of the time. During World War II Registered Practical Nurses (RPNs; at the time they were called Registered Nursing Assistants, RNAs) were introduced as demand for nurses rose over supply. The RNAs received training that was a shortened version of an RN's and focused more on technical performance, less on the underlying theoretical rationales. RNAs were required to work under the guidance of an RN, extending the hierarchy. One of the main mechanisms of today's restructuring is once more the further 'deskilling' of nurses' work, which led to massive lay-offs, increased work-loads, and replacement of nurses by lower-skilled workers, thereby producing even further stratification of nursing jobs.

Like Kalisch and Kalisch, more recently, Gordon (1997) too attributes to media stereotypes the fact that patients go through hospitals, 'seemingly without the benefits of nursing care'. Physicians, she claims, are largely credited not only with 'all of the curing but also for much of the caring'. They are seen as responsible for successes and failures within the health care system, while nurses continue to remain mostly invisible. Examining some of the underlying reasons responsible for these persistent stereo-typical portrayals Gordon draws attention to the hard-news coverage of health care in the media. Newscasts are overwhelmingly dominated by the daily reports on medical research findings, whereas nursing research is seldom mentioned. When 'health experts' are publicly quoted, they are almost always physicians or policy analysts, rarely nurses. Even lay-offs in nursing are trivialized and described in terms of labour disputes rather

than issues affecting health care seriously. She concludes that, whereas physicians are seen as professionals, nurses and their work are usually not appreciated in a professional sense by the public. Like in Nightingale's time they are perceived as medical support personnel, who characteristically possess nurturing qualities. It seems the configuration of players has not changed significantly since the time when modern health care began to be organized.

As long as hospitals provided the training, employers and doctors determined its content and standards, the 'cognitive base'. Many nursing leaders fought for control over nursing education since the beginnings of the modern discipline. In 1929 Mary Adelaide Nutting, an early nursing leader in the United States, expressed the wish to place Schools of Nursing among the "professional schools of the universities". She believed that "university education would strengthen, energize and enrich [nursing], to deliver it from some of the benumbing effects of continuous routine" (cited in Church, 1990, p.6). Another early leader and nurse theorist, Virginia Henderson, is well known for expressing a strong dislike for the 'army-style' training employed within the hospital nursing schools in the early twentieth century. Yet only in the seventies was nursing education transferred out of hospitals into community colleges and universities in North America on a larger scale. In Britain this process started even later. The ongoing push for the baccalaureate as entry to practice has finally payed off. After all these years, in Canada at least, it finally became legislated almost universally.

Nurse theorists have long recognized the difficulties nursing experienced due to its lack of distinction from other health care occupations, particularly medicine. Generally it was argued that nursing practice consists of 'independent', as well as 'dependent' functions in which nurses collaborate with the medical profession. By separating the independent from the dependent actions nursing scholars try to identify the concepts and activities unique to nursing. Thereby they are aiming to delineate a distinguished domain of nursing practice. Additionally, in an attempt to promote a more egalitarian status amongst the parties concerned, the 'dependent' functions have recently been renamed as 'interdependent'. These measures could be seen as attempts to develop a 'counter discourse', nursing's own 'regimes of truth'. In their dependent / interdependent capacity, nurses continue to follow the physician's orders. This role is the more visible one and has, for the most part, shaped public perception. It was the main focus of

education until now. Its educational material, based in the bio-medical model, was often taught by physicians in earlier times. Today nursing curricula are still mainly structured around the medical specialties. The independent nursing function emanates from 'nursing science', which is about humans as holistic beings. Recognizing the limitations of the bio-medical model in issues of 'caring', they are trying to put the 'subject' of the patient back into the 'objectivised body', that had become invisible to the medical 'gaze' (Foucault, 1973). Nursing's focus is therefore not on the classification of disease but on the patient's experience of illness. In their independent role nurses are concerned with the nurse-person relationship with patients, that promotes their healing. Currently nursing scholars are trying to build up this 'body of knowledge' to increase nursing's autonomy and efficiency.

Newman (1990) discusses the two aspects of nursing as "professional nursing and its technical counterpart". She describes the technical role as "performance of repetitive tasks prescribed by and under the surveillance of a [recognized] professional authority" (p.49), usually the physician. Sandelowski (1991) explores in a historical study how acts involving technology were controlled by medicine, such as temperature and blood pressure. Nurses would obtain and record the numbers, while physicians interpreted the readings. With many tests and treatments nurses were responsible for setting up and dismantling equipment and the before and after care of patients, while physicians would perform the actual procedure with the nurses assisting. These practices continue until today, especially in the case of new procedures. Assisting in this type of work too requires specific knowledge and judgment. In the case of nursing, which deals with the complexities of people's lives and health states, it is also very important. The systematic process, the performance guidelines, the place and time at which the interdependent tasks get carried out, are all determined officially by a professional or institutional authority other than nursing. These issues will be discussed in more details in connection with the 'restructuring discourses'. Historically and today, 'visible' hospital nursing was and is mainly comprised of this type of work (Gordon, 1998). Newman further explains that occupations performing functions under someone else's authority are easily perceived as replaceable by others.

Since the 1950s nursing scholars developed theories to guide nursing practice. Allen, Kerr and Jensen (1991) see it as a priority issue to be dealt with. Fawcett, Watson, Neuman,

Hinton Walker, and Fitzpatrick (2001) talk about integration of theory, inquiry and evidence to develop nursing's body of knowledge. The earlier theorists relied on natural science-based models, similar to medicine's bio-medical model, as they too focused mainly on health problems. However, they always also tried to encompass patients as whole persons with individual responses to the manifestations of disease. In order to enhance and expand the distinct knowledge base for nursing Newman (1986), as well as Watson (1985), Benner (1984), Leininger (1981) and Parse (1981; 1992), call for different paradigms of nursing practice with a person-oriented rather than a disease-oriented focus. Their theories are based primarily in humanism, existentialism and phenomenology versus the natural sciences. These paradigms emphasize the relational process of 'mutuality' and 'partnership' with clients, to distinguish nursing from the 'expert' paternalistic approach of conventional medicine. They are distinct frameworks that express nursing's uniqueness through its primary concern with the 'whole' person and serve as the groundwork for an independent 'cognitive base' (Fawcett et al, 2001), as nurses are trying to put the 'subject' back into the discourse on health. As this approach delineates nursing from medicine, with a distinct body of knowledge relevant ethical theories and an authentic nursing culture should follow. Nurses thereby create their own 'regimes of truth', features of professionalism that have been identified as previously lacking in nursing.

Leininger (1981) and Watson (1985) theorize caring as being the 'essence of nursing'. Benner (1984) discusses caring in more empirical terms, as it is lived and expressed through the nurse's actions and largely acquired through practical experience. Their conceptualizations of 'caring' provide theoretical underpinnings that attempt to express nursing's uniqueness. Noddings (1990, p.406) applauds the 'caring' theorists: "In affirming caring as the central concept in nursing... its struggle is inspiring to all feminists engaged in the examination of professionalism". Parse (1981; 1992) conceptualizes nursing as focused on the patient / person and his/her perspective of health and quality of life. Clients clarify their own meaning and vision of health, while nurses skilfully, and without imposing their own views or judgments, guide them as they move towards its realization. The 'subject' is thereby reintegrated into his/her healing.

Within these frameworks the patients, even though they need medical and nursing care, are seen as the 'experts' of their own lives (not the disease itself), hence are respected as partners

in all decision-making. Due to each individual's uniqueness norms can not express the whole of health as seen from this perspective. Parse's theory is the basis for 'patient-focused care' (Spee, Chua, & Nose, 2001). It is currently being introduced, as part of the restructuring process, to nurses at a major acute care, teaching hospital as well as a long-term care facility in Toronto. In the last few years Watson's and Benner's theories have also been adopted by several institutions in the city as bases for their 'caring' philosophies. In the bureaucratic healthcare institutions these philosophies can be located in the discourse of 'quality management systems' which was recently introduced into industrial production as well as public sector areas, including hospitals. The aim is to bring about continuous improvement in products and services.

In everyday life, however, the majority of nurses continue to practice from what they call 'common sense' -- mainly based in the medical science model, which they were taught during their training. The perception of its superiority largely persists. While nursing theories are being developed and introduced into curricula and work places, it seems that education and practice themselves are slow to change. The occupation in many ways seems to remain mired in the subordinate image of nursing. Altruism towards the clients served is appropriately one of the unquestioned expectations in which the occupation is based. However, Ashley encourages nurses to question the 'moral rightness' of being self-sacrificing and supportive of other groups in the healthcare field. "Their [nurses'] economic exploitation and subservient role have been universally accepted" (Ashley, 1997, p.40) thereby keeping nurses in their present low-status position. Obedience to superiors continues widely to be taught as an unquestioned virtue in nursing's educational system.

In the socialization of new practitioners the first hierarchy -- and this applies to all occupations -- is created due to the knowledge differential between teachers and students and sets the tone for future intra-occupational relationships. This hierarchical ranking seems especially pronounced in nursing, perhaps due to its roots in the military and religious convents and later the Nightingale model. As Beletz (1990) and McGregor (1996) elaborate, students are expected to be subordinate to the teachers' greater expertise, a system that filters down into the workplace and produces acceptance of an hierarchical order within the occupation itself, determining and helping to ensure accepted standards. Through this mechanism the status quo tends to be

reproduced, favouring conformity over creativity: a necessary feature to preserve standards, yet also stifling novel ideas which could lead towards an expansion of knowledge.

Bullough and Bullough (1984) explain nursing's persisting intra-occupational division as a consequence of past educational practices. As nurses, until recently, did not have their own graduate programs any nurse who desired further education had to obtain it at non-nursing institutions, such as Teachers College in the United States or the Ontario Institute for Studies in Education / University of Toronto in Canada. Thereby education outside of the occupation removed these nurses from the bedside. Yet, upon graduation, they took on positions of supervising and educating bedside nurses. Many of these elite nurses had done little actual practice during their careers, as they might have moved straight through their education. After graduation they were expected to lead and teach nurses in work to which they had little connection. Bullough and Bullough (1984) believe that many nurse educators also uncritically transferred teaching modalities from grade school to nursing education without modification, as they were familiar with this style. Some of these strategies undoubtedly were better suited to teach children than adults. They led to a prescriptive approach to teaching, versus one centred on problemsolving and critical thinking. Thereby they helped produce the docile nurse who followed orders unquestioningly. Bedside nursing, on the other hand, remained at a basic level without opportunities for acquiring and creating an expanded knowledgebase that could be of practical value to its practitioners. Despite many nursing leaders now being educated in graduate nursing schools, prescriptive protocols are still used today. In my opinion they represent barriers to nurses' creativity in providing more imaginative nursing care. They also have a 'dumbing down' effect, as nurses' knowledge, often acquired through experience, is underutilized. The lack of mutual understanding amongst nursing elite and rank-and-file nurses might be attributed partly to these hierarchical practices.

Cohen (1981, p.140) describes some of the contradictory educational practices in nursing schools that are still going on. Student nurses are told, "you are responsible and must be perfect; you are autonomous, yet follow orders and policies and make no trouble". She cites Group and Roberts who, in 1974, pleaded for nursing "to free itself from the 'ghost of the Crimea' [the demand for traditional obedience and subservience that began with Nightingale] ...Subservience

and professionalism are antithetical" (cited in Cohen, 1981, p.141). Cohen (1981, p.160) proposed altering the educational system to eliminate enforced dependency and the stifling of resistance as "a step in the direction of effective socialization" toward professionalism. A few years later Watson & Bevis (1989, p.101) explored some of the inherent tensions within nursing curriculum frameworks. They found that "critical thinking, analysis, judgment, integration and synthesis" are intellectual goals; yet "socialization happens largely in the traditional medical paradigm", where nurses follow orders. They observe that school issues, particularly in diploma programs, remain mainly 'technical'. These subjects deal largely with the best means to create a certain set of behaviours, versus "practical, [as] the creation of conditions for critical reflection and argumentation". As an alternative they propose the 'caring curriculum' (Bevis & Watson, 1989), which is now beginning to transform some of the educational approaches to nursing in institutions like Georgian College in Barrie and York University in Toronto. Their model promotes a 'learner-centred' approach to teaching, with an emphasis on critical thinking and reflective practice. However, in most other educational institutions little has changed.

MacPhail (1991) sees educational strategies as important in building up nurses' internal images of themselves. McGregor (1996) recently examined educational practices within a community college located in Southern Ontario. In her groundbreaking study she focused particularly on how 'failure' is socially constructed. She found that education continues to be aimed toward development of the 'ideal, stylized nurse' and that "subordination is sustained by the medical profession, the health care system and right-wing social policy" (p.339). During the educational process the students' confidence gets undermined, their individuality and creativity suppressed. Therefore, she concludes that, "confidence building rather than information building" should be the main goal of education. In order to change the system nurses need to learn how to 'transform', rather than 'conform' and "to break out of the dedication-domination dance" (p.340). The individual and collective perils that are inherent in this 'dance' need to be understood as problematic and changes need to be directed towards the structures and institutions that support it. Critical thinking was not part of the school's program at the time of the study. She too sees liberatory possibilities in Bevis and Watson's 'caring curriculum'.

Similarly Bartels (1997, p.4) calls for "transforming the [nursing] discipline into a

learning process in which students are central participants in creating meaning and in discovering and articulating the practice of professional nursing". Bedard and Duquette (1998) examined the notion of 'professional selfconcept' as an important factor of nurses' abilities to adapt to changes, as well as in the maintenance of their health in the workplace. They too identify strategies of a supportive, caring environment in educational institutions and workplaces as positive impacts on nurses' self esteem. They, like McGregor, call for studies of the relation of self-concept to professional empowerment. Some of my own data yield information on this issue which will be discussed later. Alie and Hales (1998) talk about the importance of increased professional awareness, including nursing's historical roots, and analysis of political issues from a critical or feminist perspective. These subjects, they reason, should be included in nursing curricula, instead of placing heavy emphasis on tasks and procedures alone. They too cite problem-based learning, an aspect of the 'caring curriculum', as a vital component.

Besides the educational system another important 'socializing agent' is the practice setting, to which nursing students are exposed during their schooling and which they enter after graduation. Donner (1986) found 'the clinical experience' and the work settings to be even more crucial for the professional attitudes amongst nurses than the educational (presumably classroom) experiences. It is in the practice settings that nurses apply their knowledge and meet the public and the nurses in the field. She therefore asks educators to pay close attention to the choice of settings and the students' learning in them. Kitson (1996, p.1652) states: "Nursing needs to demonstrate its commitment through innovative schemes that bring together its essential ingredients: empowering, enabling and educating people to take control of their lives", which should start with the practitioners themselves. Many of these scholars draw attention to the persistent intra-occupational, as well as intra-educational hierarchies, which aim for control of practicing nurses.

So far, the traditional approaches of top-down regulation have failed to bring about public recognition of the value of nursing, nor have they halted the erosion of nurses' jobs. I believe that the call for standardization of entry to practice, the 'one-size-fits-all' approach and the accompanying increasing centralization of professional regulation perhaps need closer examination. In light of nursing's wide variety of practices, different forms and degrees of



'expertise' are required, not all necessarily needing a baccalaureate preparation. I reckon it would be better to regulate these jobs from the inside than letting outside forces, such as administration, continue to substitute nurses with unregulated workers. Sawicki (1990) points out that a call to uniformity often arises from disagreements and intra-occupational tensions within the group itself, as divided factions struggle for leadership. And Nestel's (2000) exploration of the reinstatement of midwifery vividly demonstrates the dangers of one faction (white feminists) championing their cause, no matter how well-intentioned, leading to exclusion of other groups that could make equally valuable contributions. How well is a multi-cultural population served when almost all midwives are of white North American background?

The question how nursing should best proceed in its quest for greater autonomy over its own destiny continues to be hotly debated. It seems there is an almost universal agreement amongst nursing scholars on the need to free nursing from the control of other professionals, particularly physicians and administrators. Professionalism is an avenue through which occupations historically gained autonomy. In a previous section traditional professionalism, which had grown out of a paternalistic model, was examined and the professionalizations of medicine and nursing were compared. In this next section I will discuss the suitability of the traditional model for nursing and look at some alternative views on what a 'new' professionalism could look like.

### **Nursing and Professionalism: Alternative Views**

Cohen (1981) explores the status of nursing's professionalization. She defines a profession as a "collective, held together by a common ideology, a common style of work, a shared mystique and usually a technical language" (p.11). She believes that nursing possesses many of the necessary characteristics of a profession, particularly altruism. However the following factors are identified by her as remaining obstacles to professionalization in nursing: 1) a lack of theory, 2) a lack of recognition by society, 3) a lack of shared ethical codes, and 4) a lack of a shared culture. Nursing, she claims, largely uses others' knowledge, mainly medicine's and psychology's, including the ethics of these professions. Due to being subordinated to others' authority and carrying out their work, nursing culture too is shaped through these professional

groups. Church (1990, p.5) calls this practice the "mis-alliance with the medical ideology and disease orientation with 'cure' as its goal". Nurses thereby collaborate in the subordination of their own professional issues to medicine's dominance. In the process nursing issues are seen as unimportant. The public, unaware of nursing work, does not perceive it as separate from medicine. Even nurses themselves seem to measure their success and worth in how closely their job resembles the medical model. The high status that nurse practitioners hold within the general nursing population is an example. Valentine (1992) and Robertson (1984) identify the often resulting open devaluation by nurses of nursing and each other as 'oppressed group behaviour'.

Many others, including professional bodies like the Registered Nurses' Association of Ontario (RNAO) and the Canadian Nurses Association (CNA), blame the lack of a standard education for entry into practice until now as the main barrier to obtaining a monopoly over the knowledge base and the work itself. Aydelotte (1990, p.10) advocates for building a "strong professional association" as "one of the major catalysts in the movement of an occupation toward achieving professional status". Even though the College of Nurses of Ontario (CNO) has its own 'ethical code', it had been very general in the past without acknowledging nursing's specific areas of concern. Recently the CNO has begun to define the competencies and professional practice guidelines more clearly as they specifically apply to nursing. Lambert and Lambert (1989) see nursing as an evolving profession that still needs work in areas such as clarifying nursing's uniqueness and image and a sense of community amongst nurses. Johnson and Webber (2001, p.220) state: "Nursing has made significant strides to position itself in higher education, expand the body of nursing knowledge, participate in educational programs and increase the autonomy of practicing nurses. Although most nurses are effective and committed caregivers, they do not meet full professional status and remain professionals by licensure only". They believe that nursing continues to lag behind in the numbers of nurses prepared at the graduate level and their abilities to link their knowledge more closely to nursing theory.

In general nursing leaders seem to agree that achieving full professional status is the route toward autonomous practice. However, with regard to what professionalism is, and how to achieve it, conflicting opinions exist. Many nursing scholars seem to embrace traditional professionalism uncritically. They fail to recognize and question the contradictions and tensions

between self-serving imperialistic and altruistic goals, that were discussed earlier as inherent in professional elitism. The resulting ethical questions/dilemmas are overlooked as the concept of professionalism is treated as reified and unproblematic. How it is understood and displayed by the classical professions, continues widely to be seen as the gold standard. For example, in recognition of the power and influence of elite strata in society, Beletz (1990, p.21) advocates that nurses should “market [nursing’s] service for the wealthy”. After all, this was an effective strategy employed by medicine in the past. The issue of medicine’s substantive monetary rewards seems to be a measure of success in her view.

Moloney’s (1992) writings are another typical example of an adherence to unquestioned views and values. In her book Professionalization of nursing she discusses nursing and medicine in relation to where they are located on “the occupation-profession continuum” (p.19), which is modelled after the ‘ideal type’ of the classical profession. She emphasizes the necessity for nursing to reach full professional status by following the medical example. The biggest obstacle to its achievement, she claims, are the nurses’ own attitudes. A majority of them, she feels, show a lack of commitment to the goal of professionalization, hence these nurses are dismissed by her as ‘uninvolved’ and ‘undeserving’. Moloney pays little attention to historical and present societal contexts and the multitude of factors that play a role in this issue; nor does she perceive the concept of professionalism itself as problematic. Seemingly out of touch with nurses’ reality she blames the nurses’ apathy as the main reason that nursing has not attained professional status so far.

Others act as if nursing were already a full profession. Hamilton (1996, p.26) claims that “nursing meets all 12 criteria of a full profession. It is a proud and extraordinarily satisfying profession with a rich history and a challenging future”. Her 12 criteria include specifics such as competence, commitment and prestige in addition to the other traditional markers mentioned earlier. In the university where I teach it seems to be a taken-for-granted assumption. The handbook of the School of Nursing (Ryerson University, 2000/2001, p.7) states : “Nursing is a humanitarian caring profession, guided by ethical and legal standards and accountable for the advocacy of clients, peers and the discipline itself”. In addition two of the ten program outcomes contain sentences further alluding to professionalism: [The student] “practices nursing within

legal, ethical and professional guidelines” and [the student] “is an active participant in her/his professional development” (p.7). The second assumption is therefore that the curriculum facilitates professional development of students as future practitioners. Yet ‘professionalism’ is nowhere defined or explained. By treating professionalism as a ‘given’ it is left open to individual interpretations or accepted ‘as is’.

By building on taken-for-granted assumptions critical examination of ‘professionalism’ is not encouraged. The implications of societal changes in form of rising consumer awareness, the general movement within the population toward self responsibility and the impact of these factors on professional practice are thereby also mostly overlooked. Not enough attention seems to be paid in nursing to the fact that traditional professionalism is now being questioned by some of the scholars of the social sciences and that models of a ‘new professionalism’ based on feminist values (Davies, 1995) are emerging. Displaying a more insightful vision White & Begun (1996, p.79) hope for nurses to emerge as leaders, “who may best guide the total care of the patient”. Rather than striving to keep the status quo they call for responsiveness to the changing needs of society, more flexibility, which should start with more tolerance towards their own colleagues, and more “measurable contributions” (p.85) within the health care system, in other words to become more ‘visible’. Curtin (1996) seems to agree. She too encourages nurses to make their contributions to patients’ recovery better known, and to become stronger team players within the system.

As discussed before, ‘exclusive knowledge’, as it was developed by the classical professions, served to mystify and thereby greatly further the professionals’ own interests. As they became its privileged ‘gatekeepers’, a monopoly was established. Disciplines create the rules for their work, which is sanctioned by their ‘veridical discourses’. Barrett (1991) describes the ‘truth’ that is thereby constructed, not as a property of the discourse itself but a “property of the referent of the discourse”. It authorizes the professionals’ work, and can become an automatic warranty for its worth. Thereby, she claims, professionals are setting apart their own membership from the rest of the population. To ensure that all their members are adhering to the ‘truth’ is enforced by ‘discursive policing’. “Within its own limits each discipline recognizes true and false propositions...Science was institutionalized as power and the ‘will to truth’ is a key dimension of

that historical process" (Barrett, 1991, p.143). As a result gate-keeping strategies are employed in the form of surveillance of and control over its own members, by enforcing the status quo, which always comes at the cost of innovative ideas. Falk-Rafael (1996) too critiques the traditional unquestioned acceptance of 'professionalism' according to the 'received knowledge' structured within 'male norms', that mainstream nursing still continues to be after: "If you can't beat them join them" (p.12), seems to be their attitude. Thereby the status quo is effectively reinforced and perpetuated. She too proposes that nurses begin by valuing and supporting each other and by practicing 'empowered caring' which is based on respect for others and self. It arises from the elements of strength, assertiveness and mutual support.

Many of the critical views expressed in the literature are based in feminist values. Ehrenreich & English (1973) see nursing issues as inseparable from feminist issues. They disapprove of the mode of access to 'male' professions historically by some groups of women, who fought for and eventually gained acceptance. Unfortunately once there, many complied with the existing standards and became 'one of the boys', acting themselves as 'oppressors'. To these authors "professionalism is - by definition - elitist and exclusive, sexist, racist and classist... Women who sought formal medical training were too ready to accept the professionalism that went with it... They made their gains in status - but only on the backs of their less privileged sisters - midwives, nurses and lay healers" (p.42). The authors feel that thereby they became traitors to their own gender. Other examples of oppression of their own members are discussed by Robertson (1984) and Valentine (1992). They describe how nursing leaders, particularly those in management positions, tend to side with hospital administration against their own staff.

Davies (1995) critiques professions as embracing the ideals of mastery, objectivity and emotional distance and the assumptions of universal values, which are not compatible with nursing. She argues that "nursing's long-term project may therefore be not to become a profession in the present sense of this term, but to challenge the gendered basis of the concept" (p.61). She recommends to envision nursing as a 'new' profession with the focus on "sustained encounters...more holistic and less hierarchical and multi-tasking skills some of which require considerable training and others not" (Davies, 1995, p.90). Further she exhorts us to make a clear distinction between 'care-giving', the unpaid caring that is done at home and 'care work' or

professional care, which is based in a body of formalized knowledge. This distinction is necessary to escape the notion of caring being 'natural' to women and to "dislodge the gendered model of profession" (p.149). In her view, a nurse practicing ethically should be "neither the master/possessor of knowledge nor the user of experience but a *reflective user of experience and expertise* [sic]" (p.150). For Davies the traditional model of privileged knowledge carries too much 'old baggage'; she believes that in many aspects it is "antithetical to what nurses wish to do" (p.152). A 'new' professionalism should include the values of community and engagement versus competition amongst the members. Instead of the distant, autonomous 'expert' role of the past it should be based in an egalitarian interdependency with other professionals as well as the public served.

Along the same ideas Ashley (1997, p.190) too encourages reconceptualization of professionalism from a more humanitarian perspective to "establish a community of sharing and caring", which seems truly compatible with nursing values and should start with the practitioners themselves. She draws on feminists like Virginia Woolf, who long warned of the uncritical acceptance of male professional values and raised the question of why women would want to enter male professions or become like male professionals, "possessive, jealous of any infringement of their rights, and highly combative if anyone dares dispute them" (Woolf, 1938, p.66). New perspectives suitable for nursing might also be glimpsed from the feminist works of Mary Daly (1990) and Adrienne Rich (1986), in which they proclaim that feminism is devoted to the preservation of life and health and a harmonious eco-system -- issues that are much in the foreground today.

In a recent public presentation in Toronto (RNAO conference, April 2, 1998) that I attended Suzanne Gordon, a journalist, and Doris Greenspun, a nurse scholar and executive director of the RNAO, nursing's professional body, were the keynote speakers. They both urged nurses to "get rid of the image of the angel", which allows for nurses' exploitation by other groups in the health care system. Both speakers encouraged coalition building with 'patients' and other nurses, an upholding of an ethics of 'humanistic caring' and better information of the public about nurses' work. Similarly, in regards to 'restructuring', Matthews (1998), like McGregor (1996) whose work was discussed earlier, calls for getting rid of the "good

unquestioning nurse" image. In practical terms, Matthews (1998, p.7) states, nurses need to think about and clearly articulate what they can offer, "that an unregulated worker can not". They can no longer afford to sit back and wait for everything being handed down to them, "or it literally will be handed down to them -- our future will be decided by someone else... and nursing disappears into the sunset". Her warnings are echoed by Mitchell and Cody (1999) who express similar concerns around the need for a distinctive identity for nursing. They too fear that, if we can not learn to demonstrate our value, we will be entirely replaced by unregulated workers and technicians, such as 'physician assistants'.

### Summary

In this chapter I have attempted to trace nursing's undervalued position within the healthcare hierarchy to the historical contexts in which it took shape, particularly in relation to medicine. I have also pointed out that hanging on to the predominant view of professionalism by trying to emulate physicians creates difficulties for nurses. It prevents them from envisioning new ways more compatible with nursing values based in humanism rather than solely in natural sciences. There is a common perception that nurses' 'lack of power' within the context of women's position in society prevented them from becoming autonomous professionals in the past. They are predominantly portrayed as vulnerable 'victims' who were taken advantage of by the more 'powerful' professional groups in the healthcare system, such as physicians and hospital administrators and sometimes their own nursing elite. Today the prevailing counter strategy of many nursing leaders remains to achieve full 'professional status' for nurses, thereby trying to 'elevate' them to the level of the other more powerful professions. Yet their uniquenesses and differences are thereby ignored. Also, as we have seen, physicians were able to strategically position themselves as 'experts' of health and to produce a powerful history of 'truth' (see Foucault, 1973: The birth of the clinic) that is hard to challenge.

Some counter discourses for defining and creating nursing's own distinct knowledge base have been developed by a number of nurse theorists over the last fifty years. This knowledge is slowly seeping into and beginning to guide nursing practice and education. A baccalaureate degree will be the required entry to practice level by 2005. Less success can be reported in the

area of autonomy, as there is no universally recognized 'regime of truth' that would give nursing full professional status. At the political level nursing's professional and regulating bodies are beginning to play a larger role. Recently the professional nursing association of Ontario (RNAO) has become more involved in politics and policy formation. There are closer ties with the ministry of health, as some of their leaders -- such as the chief nursing officers, Judy Shamian at the federal and Kathleen McMillan at the provincial level -- are now consulting about health care issues. But alone, this strategy is not enough. The leadership's interests and world views are often of a different nature than the rank-and-file's. Practicing nurses too need to make themselves and their concerns heard, for change to occur that is meaningful at the level of care delivery. Despite some improvements, everyday nursing practice is still regulated from outside the discipline by hospital administrators and even physicians to a large extent, as we will see. Nurses were helpless in the face of lay-offs during the recent cutbacks. They and their unions were unsuccessful in protecting their jobs from being deskilled and downloaded to unskilled labour. The College of Nurses of Ontario (CNO), unable to take a strong stand for their members, even prescribed that nurses be accountable as RNs when working in lower job categories and for much less pay, seemingly playing into the hands of those responsible for exploiting nurses.

Traditional professionalism, as it was/is displayed by the classical professions, remains the unquestioned ideal of many nursing leaders, despite its problematic aspects. In the meantime, as all the attention is directed on this utopian goal, the needs and everyday realities of practicing nurses remain largely unknown. As frontline workers continue to be excluded from the decision making process, the resulting intra-occupational tensions between the rank-and file nurses and their leadership further weaken nursing's strategic positions and worklife conditions deteriorate. Nursing's contributions to healthcare remain largely undervalued and underutilized, exploited by other societal groups not only to their own, but also to the public's loss. The external constraints imposed on them, their intra-occupational disunity and their own perceptions of their work are in the way of societal recognition of nurses' contributions and the protection of their jobs. This position also precludes the critical examination of the issue of professionalism itself and nursing's oppressive practices within their own ranks.

I believe we need to carefully examine and (re)-define what nursing is about and from



there to identify how we want to shape the profession. One of the key issues in an occupation's status and ability to act is 'power'. Others are self concept and public perception. I have chosen Foucault's thoughts on power and subjectivity as conceptual framework for this project, as I believe his ideas to be the most innovative and practical for examining societal relationships and their dynamics. He also worked from the assumption that, to be effective at local sites, change needs to happen at local levels and should come from the inside, which is congruent with my own views. The following chapter outlines Foucault's ideas from which my conceptual framework is derived and from which my data will be analyzed. It ends with a section on the current 'dominant' discourses behind restructuring, coming out of 'managerial science'.

## **CHAPTER 3**

### **CONCEPTUAL FRAMEWORK**

#### **Introduction**

In this chapter I will discuss the study's conceptual framework, which is based in Foucault's ideas on power and subjectivity. It guided the design and later the analysis and interpretation of the data. I chose Foucault's conceptualizations of power / resistance and subjectivity because they are focused on the local level in the everyday world where power strategies take effect. Power works within and through the relationships of individuals with each other, which are always inherently unequal and unstable. It is put into action through the 'micro-practices' they engage in. In my study I am examining the effects of restructuring on the work and lives of nurses, as they are perceived at the point of impact and in which the nurses, as active players, also participate. Exploring restructuring from the local level by beginning at the bedside, I hope that its mechanisms and the discourses behind it can be made visible, raising the awareness of nurses about how they actively participate in them. Thereby other possibilities might be envisioned for bringing about changes to improve the quality of worklife for nurses and quality of care for patients.

#### **The Repressive Hypothesis Model**

Most conventional theorists discuss power as something that is possessed by some groups and lacked by others. The reasons for the differentiation range from one's positions in economic terms -- the haves and have nots -- to being perceived as possessing or lacking important knowledge, such as professionals and the subordinates who work for them. Concepts like class or gender are the core around which the theories tend to be organized and through which groups in society are ranked. Depending on their position groups are perceived as either powerful or powerless, either wanting to maintain the status quo or to overthrow it. Power is seen as an instrument of oppression and therefore invested in authoritative societal structures, like schools, the military, the state. It is monolithic and works from the top down, even though it might meet 'resistance' at the 'micro' level. Within this framework there is a reality that can be discovered, a

truth about the workings of power that can be found. Change can be brought about by reshaping society's structures and its organizational systems, either at the macro- or micro-levels: an utopian goal lacking effective strategies to deal with the situation in the meantime (Sawicki, 1988).

Foucault discussed and critiqued the conventional binary framework for the analysis of power relations as 'the repressive hypothesis model' (Foucault, 1990). Power in this sense has largely a prohibitive function; as the 'can' in the realization of outcomes as one desires them, it works through the ability to say 'no' to others, thereby directing their agencies; in Connell's words: "Relations of power function as a social structure, as a pattern of constraint on social practice" (1987, p.107). Within the 'repressive hypothesis model' the investigation of institutional power relations starts with the organizational structure. One examines how power is possessed or lacked by the people occupying the various positions. The factors that do not fit in tend to get ignored, even though they have, or might have led toward important strategies for change. For example in nursing's history an analysis along class, race and gender lines, like the one used by some of the authors in the previous chapter, leaves out the doctors and administrators who supported nurses. As it portrays them primarily as passive, 'powerless victims', it also leaves out or downplays the ways power worked productively for nurses, how they were/are able to mobilize discourses, expertise, as well as different forms of resistance that were and continue to be practiced by nurses. After all, despite the factors which maintain nurses' oppression, many changes for the better have been brought about. Nursing education, for example, moved out of hospitals and into the post-secondary education system; yet the handmaiden image of the nurse persists, suggesting more complex forces at play. From a binary perspective of power such contradictions are hard to explain. They are difficult to fit into the either/or positions that many of the 'grand theories' of class and gender adopt.

Foucault believed that relying on such overarching frameworks is not the most productive way to examine power differentials. He warned that an illusion of 'false continuities' might be created by a mode of analysis whereby all aspects of the development of social institutions tend to be viewed as a linear progression of identifiable cause and effect relationships in a systematically coherent manner. He believed that chance often plays a major part in what happens.

As Diamond and Quinby (1990, p.xiii) state, "Foucault warns against the seduction of totalizing theory, which appears to resolve all differences through unified and cohesive explanation". In a similar vein Rolfe (2000) encourages us to show 'incredulity' towards the 'meta-narratives' -- to question their 'authority as truth games' (p.44). One such authoritative discourse in healthcare, and a driving force behind restructuring, is the 'managed care' perspective, based in managerial science. It will be discussed in the last section of the chapter. However, in addition to change from the inside at the local level, the feasibility of concerted action at the collective plane to avoid ineffective fragmentation should not be discounted entirely.

### **Power/Resistance from a Foucauldian Perspective**

To overcome the limitations of the traditional views of power Foucault called for an expansion and redefinition of this concept. He provides us with a guidance for inquiry and method, rather than a 'theory' of power. He believed there are always many modes of power at work simultaneously. Modern forms of power are often neutral and productive forces rather than solely adversarial ones. Unlike 'sovereign power' modern power's main mechanism is not imposition from above; it mostly works from below, starting with the micro-relationships between people and 'techniques of the self', which enable its workings. Martin (1988, p.6) explains: "It is induced in the body and produced in every social interaction. It is not exercised negatively from the outside, though negation and repression may be one of its effects." It permeates individuals and everything they say and do. Foucault therefore suggested to investigate how power works from the inside, from people's self perceptions, encompassing all aspects of their relationships in their complexities, not only the oppositional ones. These practices produce heterogeneous effects, yet always within the historical context of a material world, as Foucault (1980, p.188) explained:

The notion of repression is quite inadequate for capturing what is precisely the productive aspect of power... It is not built up out of 'wills' (individual or collective) ...it is constructed and functions on the basis of ...myriad issues, myriad effects of power. That is not to say that it is independent or could be made sense of outside of economic processes and the relations of production.

Foucault stated that we need a different perspective, something like of a 'new economy of

power'. Consisting of a 'myriad issues and effects' this economy is located within and depends on all the other social processes and contexts, past and present, which make its workings possible. Exploration of any issue therefore best begins with

...the ascending analysis of power, starting...from its infinitesimal mechanisms, which each have their own history, their own trajectory, their own techniques and tactics, and then see how these mechanisms of power have been -- and continue to be -- invested, colonised, utilised, involuted, transformed, displaced, etc., by ever more general mechanisms and by forms of global domination (Foucault, 1980, p.99).

Power thus circulates freely within societies and is exercised from "innumerable points, in the interplay of non-egalitarian social relationships" (p.119). Power is therefore always relational; it is expressed in 'strategic games' which are played according to an 'assembly of rules'. Although power is neither possessed by persons, nor constructed by them at will, nor imposed from above, everybody always partakes in it. It "exist only when it is put into action" (Foucault, 1982, p.788). From its origins in everyday practices its mechanisms extend into and impact on the larger societal and global issues.

To explore issues of power from this perspective the first question is not: "who is powerful?" As Barrett (1991, p.136) explained, for Foucault, "the who of power can only be studied with the how". One does not start with the institutionalized systems. Instead, one asks, how does power work and by what mechanisms? What strategies do the participating 'players' use in their 'games'? What 'assembly of rules' do they follow? Far beyond solely power's oppressive effects one looks for its productive aspects, "...the procedures which allow the effects of power to circulate in a manner at once continuous, uninterrupted, adapted and individualized throughout the social body... it [power] induces pleasure, forms knowledge, produces discourse" (Foucault, 1980, p.119). Therefore Foucault suggests one begins by investigating, at the local level, 'how power works'. It needs to be remembered that present context and its historical inceptions impact on the mechanisms of power. Therefore the mechanisms should be examined and their relationships to societal discourses traced, as they express the aims of the political apparatuses at play. For Foucault there are no single mastermind programmers, no headquarters

where power emanates from, only various 'blocks of power' and 'agents' who practice within them. Relationships amongst players are constructed as they take up positions within competing discourses. They often produce unexpected results, that no one in particular desired. Due to the multiple factors at work creating numerous possibilities, the outcomes of these relationships can be much less predicted and controlled than conventional thought systems of the cause-effect paradigm would have us believe. The results are co-created to a large extent by chance and often take unexpected turns. Therefore some, like Hoy (cited in Spivak, 1993, p.27), go as far as saying: "Foucault thinks of power as intentionality without a subject..."

For Foucault, how power works is closely associated with 'knowledge' and 'pleasure' and their production. It goes hand in hand with 'truth'. Truth here is not seen as absolute but instead is always attached to power and contingent on it, therefore negotiated between participants:

Each society has its regime of truth, its 'general politics of truth': that is the types of discourses that it accepts and makes function as true: the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those which are charged with saying what counts as true (Foucault, 1980, p.131).

Truth is hegemonic knowledge that circulates in the form of 'veridical discourses'. By forming 'regimes of truth', these discourses represent the 'organized and organizing practices' of power. In other words the 'political economy of power' largely operates in the form of a 'political economy of truth' and circulates in the form of discourses of 'science'. By speaking the truth in the language of science one exercises power. "Truth is linked in a circular relation with systems of power which produce and sustain it, and to effects of power which it induces and which extends it" (Foucault, 1980, p.133). Its workings can be seen in our worship of and reliance on 'scientific' research, which pervades our technology based, rational society. Media representations show our lives to be organized and evaluated around 'research findings'. Our productions and consumptions are based on these veridical discourses and justified by them. The 'scientific discourses' historically and today privilege the medical professionals. They became

integral to and were themselves constituted as experts within the scientification of medicine that began in the late 18th century (Foucault, 1973). As professionals they justified their 'high status' by claiming the monopoly on knowledge about diseases and their cure, positioning themselves as the referents of this discourse. Their assertions then were invested in and colonized people's bodies as, during the last few centuries, people's lives began to organize around individual and population health, as I will discuss later. Hospitals and educational institutions represent the 'organized systems of power' in which the 'scientific truths' were produced, invested and sustained. The high status and class positions they conferred on the medical practitioners, in turn, facilitated their autonomous professional regulation with little outside interference. In a circular fashion the production and effects of power reinforced each other and continue to do so, enabling professionals to hold on to their elevated status.

To understand the intricate workings of power and to develop effective strategies for resistance Foucault suggested that we examine the 'discourses' integral to the processes at work. In this mode the distribution of power in its complexities, as it is particular to a given social organization, can be revealed. Foucault explained:

It is in discourse that power and knowledge are joined together...[in] a multiplicity of discursive elements that can come into play in various strategies. It is this distribution that we must reconstruct with the things said and those concealed, the enunciations required and those forbidden, that it comprises; with the variant and different effects according to who is speaking, his position of power, the institutional context in which he happens to be situated... (Foucault, 1980, p.100).

The analysis does not end with the establishment of power distribution. For Foucault all discourses have the potential to be "both, an instrument and effect of power...but also a point of resistance. Discourse transmits and produces power; it reinforces it, but also undermines and exposes it...makes it possible to thwart it" (p.101). Therefore once the workings are understood, different players, regardless of their position within the hierarchy, can use the 'discursive elements' to their own advantage, infusing them with different meanings. By developing a 'counter' or 'reverse' discourse one can bring about change in relationships of power from 'the inside'. This means using the same words but reorganized to be congruent with one's own

perspective.

Within the 'social network' the discourses of truth regulate the 'relations of power' in which all of us are always already situated and from which we can not escape. They are played out in the myriad of what Foucault calls, 'capillary relationships', meaning people's everyday encounters and practices with each other. Capillaries are the smallest microscopic bloodvessels in the body. The bigger bloodvessels, resembling the branches and twigs of a tree, merely transport blood from the heart through ever smaller arteries, or carry the blood back to the heart within ever larger veins. Between these two systems capillaries exist everywhere in the body as the functioning units. It is at this level where the important life sustaining processes take place, where the actual exchanges occur that ensure the survival and performance of the organism. Nutrients are delivered and waste products taken away. Similarly Foucault believed that power, as an ubiquitous force, traverses society. It gets induced at the local level of individuals' bodies in the form of their beliefs and values which determine conduct. That is where its effects are ultimately played out. It is the site where we can observe and explore the relationships in which everyday practices take place. They can also be changed at this level effectively through localized resistance.

This form of power manifests itself when it is put into action. It represents itself as "action upon the actions of others" (Foucault, 1982, p.789), actual as well as potential. This means that power has the capacity to direct the conduct of the participating partners. Societal activities are regulated by policies and rules. Adherence to them is reinforced by various mechanisms of 'surveillance and control'. Each relationship, by necessity, is based on power differentials, such as those between hospital administrator and nurse, teacher and student. Each entails expectations of behaviours, congruent with each partner's status. The resulting differences in each participant's position produce complex effects, an "ensemble of actions, which induce other actions and follow from other actions" (Foucault, 1980, p.217). The partners 'know their places'. These relationships in the traditional views on power are conceptualized as 'fixed' and regulated in institutions and imposed from above. For Foucault, however, they are 'unstable mobile force relationships' that manifest themselves locally everywhere in various forms. The emphasis is not on 'capacities' but on the 'freedom' of the actors within these relationships to



act, to make choices; in fact liberty is the essential precondition for power; therein simultaneously lies its ever present instability.

As these relationships are forever unstable, they even may be reversed at any moment as their context changes. An example would be the teacher / student relationship. A teacher is in a more powerful position in regards to (usually) having more knowledge about the topic taught, having the advantage of judging the student's work and being authorized to grade it. Students too have recourse to strategies which they can utilize, such as the official appeal process for a grade they consider unfair. However, institutional appeals are quite cumbersome and time consuming, as they depend on other persons and committees being involved. Frequently easier, and more effective, are more anarchistic 'acts of resistance'. For example, students can give teachers unflattering feedback like poor evaluations regarding course material and teaching ability. They can also passively resist by withholding their participation and enthusiasm for the subject taught. They thereby can affect the teacher's sense of competence and self-esteem. Finally, in a different context and with a different topic the student might have greater knowledge and become the teacher to the teacher, who then becomes the student. With the knowledge of and working within the dominant discourses at play, the appropriate strategies can be found through which these relationships and their apparently inherent power differentials can be challenged or reversed.

Manifest in actions, systems of power relationships can be seen as the product of what Foucault calls a constant 'agonism of strategies'...'a relationship which is at the same time reciprocal incitation and struggle, less as a face-to-face confrontation which paralyzes both sides, but a permanent provocation" (Foucault, 1982, p.790). The term 'agonism' is often used in relation to chemical agents or muscles. Chemical agents can reinforce effects of each other. Medications are often prescribed together, as they increase certain, desired outcomes. In the context of muscle function, agonism refers to muscles working together as a group to bring about specific movements. In order to effect necessary adjustments there is a constant change in the force of contraction of individual muscles, always intensifying in some of them, and diminishing in others. Because the changes are so minute, they are hardly noticeable. Agonism, in this sense, essentially describes a synergy, a collaboration to bring about various types and degrees of motion, always in support of the muscle group that momentarily prevails. With the common goal

of a certain movement there occurs a constant shifting in balance and strength amongst the muscles that work together. Similarly in all relationships there are continuous manifestations of slight shifts in power balances. They appear as various degrees of unstable, subtle domination, yet overall produce a collaborative effect. Even though in agonistic practices there might be some minor points of contention, in general the forces all pull in the same direction. In reference to the medical profession, as we have seen, its practitioners' achievement of 'autonomous' self regulation became possible through their agonistic practices, in earlier times with the Church, and later the State. Through legislation and administrative support the professional rights and obligations, the due process of meritocratic selection procedures were ensured and monitored within the institutions of education and practice, such as the university and the hospitals. All parties involved also benefitted, reinforcing each other's positions. Where these agonistic strategies could not be exercised, as was the case for female occupations, professionalization was not achieved.

Sometimes a more forceful open confrontation occurs and becomes visible at the 'points of resistance'. Foucault referred to this phenomenon as an 'antagonism of strategies'. For chemical interactions, like medications, it means they counteract each other through their opposing effects. In relation to motion it refers to the actions of one group of muscles and its antagonistic other, a group that brings about opposing movements. Here the direction of force may openly and abruptly change. The two muscle groups have now opposite goals. The balance of power will shift in favour of the group of muscles which is able to muster the greater force. The abrupt change in the direction of the movement makes the opposing action visible. Bedford-Fenwick's resistance to the traditional role of women in society and the 'registration movement' she led for female occupational groups is an example of 'antagonisms of strategies': her goals were at odds with the state, society and Nightingale. However both mechanisms, agonism as well as antagonism, vary more or less only in the degree they change and act on the relationships; one can turn easily into the other at any time: for example registration was eventually obtained, along with other changes. For Foucault power is always most easily investigated at the 'local level' and particularly at the 'points of resistance'. It becomes most apparent when it needs to 'flex its muscle' and resistance is its 'raison d'être'. Without resistance or at least its possibility there is

no need for power. An important point here is that both mechanisms, the agonisms and the antagonisms presuppose a 'free play' of interactions, to allow the relationships concerned potentially to be reversed at any moment.

Power's unstable modes of domination have to be distinguished from complete domination. The latter is not seen as a 'power relationship' in the Foucauldian sense, which always supposes a 'freedom of the actors to act'. Complete domination 'suspends power' since resistance is no longer possible. In reference to muscles it can be compared to complete paralysis. In this situation there is no longer a possibility for reversal. Muscles are 'frozen' in their positions. Neither an intensification of movement nor resistance are possible; the usual 'free play' is suspended. Although complete domination of the other is what power aims for, once achieved it negates its own existence. It takes away the freedom of the 'actors to act', which is the necessary prerequisite for power in the Foucauldian sense.

Power then is seen as a force acting in relationships between partners, inherently imbued with possibilities for change and resistance. All relationships are also always embedded in a whole network of other power relationships. They are forever affected by everything around them, the 'neighbouring practices'. Davidson (1997) and Veyne (1997) compare Foucault's networks of power to semiotics: in language all words are connected to and take their meaning from other words. Language consists of strings of 'signifiers' and 'signifieds', words infused with meanings, that define, and in turn are defined by each other. Language therefore represents a process that is forever dynamic. As soon as a meaning is established, its "relationship to the present, the reference to present reality, to a being -- are always deferred" (Derrida, 1981, p.29). It is this constant production and shifting of meanings that is represented in and through language. Similarly power relationships always all affect each other and are each other's context. The shifts in power differentials are constantly taking place and happen simultaneously at many levels. Usually they consist of a 'seamless' tightly knit arrangement of relationships, in which societies are organized. These 'blocks of power' move together simultaneously as the 'truth' and who can speak it shifts. Over time professionalism had migrated from status group to social class. Changes such as who could be included, educational requirements, systems of rewards, gate keeping practices and knowledge production took place during this process. These shifts

happened as countries were experiencing the loss of the Church's hegemonic status, the emergence of civil societies, scientific discoveries, the rising capitalism and its demographic changes -- constituting the network of power relations that mutually affected each other.

Despite the tightly interwoven societal network of relationships that are perceived to be shifting constantly and mostly in unison, it also happens that occasionally an empty space is created. To increase one's participation and influence Foucault (1982) suggested there is a process of whereby groups or individuals 'squeeze into the spaces of freedom' that open up, as 'chance' events change the configurations of these relationships: for example the State filled the void when the Church began to lose some of its power. Chance events play a significant role in Foucault's conceptualizations, introducing / explaining the 'discontinuities' we often discover, the unexpected which renders all predictive models / explanations so inadequate. It is also important to remember that power strategies are always what Foucault calls 'exceptional'. They each represent one possibility within a whole field of possibilities. The same scenario can be played many different ways, hence there are always opportunities for change. That is why there are always surprises, 'exceptions to the rule', things that do not 'fit' into the overall scheme.

Foucault (1982, p.780) stated that power relations can best be identified and examined by "taking the forms of resistance against different forms of power as a starting point... Power thus conceptualized is more empirical, more directly related to our present situation". These oppositions are what Foucault terms 'anti-authority struggles'. As immediate, local struggles they are usually unorganized. They are expressed in acts of mostly anarchistic defiance to authority, such as non-compliance with treatments imposed by authoritarian healthcare professionals or individual acts of sabotage. "The aim of these struggles is the power effects as such...the medical profession is not criticized primarily because it is a profit making concern but because it exercises an uncontrolled power over people's bodies, their health, and their life and death" (Foucault, 1982, p.780). The struggles therefore are always directed against the techniques of 'objectivization', which are perceived by individuals as forms of exploitation, domination or subjection of themselves, a form of power, "...that categorizes the individual, marks him by his own individuality, attaches him to his own identity, imposes a new law of truth on him which he must recognize and which others have to recognize in him..."(p.781). Of these three techniques

exploitation is thought of mostly in the economic sense as the right of others to the appropriation of one's material gains, without return of fair rewards. Domination could be related to categories such as gender, ethnic origin or social status, signifying privilege and control of one societal group over others on the grounds of its inherent superiority. Lastly subjection concerns "the submission of subjectivity" (p.782), such as how patients feel they are perceived and treated by healthcare professionals. Usually all three types of objectivizations are mixed together and go hand in hand. Foucault believed that in recent times subjection is the leading technique. Therefore, he suggests, subjectivity and power need to be examined together.

Beginning with acts of resistance at their local level where they occur, and the counter strategies they provoke in turn, should lead us to understand the power relations they are trying to dislodge. Resistance as a 'chemical catalyst' brings to light the power relations, hence helps locate their position, their application and methods used... "[The process] consists of analysing power relations through the antagonism of strategies" locally, because "resistance is usually directed against the immediate, rather than the chief enemy", who is often unknown. For Foucault (1980, p.133), the problem is not "changing people's consciousnesses -- or what's in their heads -- but the political, economic, institutional regime of the production of truth". The question is which are the forces that make it possible for something to be regarded as a 'truth' in the first place? He suggested we need to detach the power of truth from "the forms of social, economic and cultural hegemony, within which it operates at the present time" (p.133) and make it visible. Therefore we need to examine what counts as truth and why. We have to try to expose the system itself rather than finding the fault with individuals for failing to adapt to it or correcting it. An example would be nursing leadership blaming staff nurses for not acting 'professionally' and therefore scapegoating them for nursing's inability to obtain professional status. A more productive strategy is to examine the discourses of professionalization within their historical and current contexts, in order to discover what the nurses' resistance is directed against. Subsequently one can work for change from within by reshaping the elements of professionalization to fit nursing's values.

### **Subjectivity as Government of Self**

Government is the major complex form of power that traverses society. In Foucault's (1991) terms it is more than the institution of the state itself. It is 'the conduct of conduct'. As Martin (1987, p.6) states, for Foucault "the state is not the origin but an overall strategy and effect", hence not a site where power simply resides. Government is made up of multiple centres and mechanisms. It is about people's relations with wealth and resources. However, it also deals with their customs, their thinking and acting, as well as management of misfortunes like epidemics and death, "the complexity of men and things" (Foucault, 1991, p.91). Dispersed broadly everywhere at all levels of society it is exercised at multiple sites. As the 'art of government', which basically means knowing ways in which this activity might be carried out, it was deployed historically in the form of three major mechanisms: First as the 'selfgovernment' which is connected with moral conduct. Then there was the governing of the economy and lastly the general ruling of the state. With the advent of capitalism the latter two became merged: the economy was introduced into the general running of the state "...for the common welfare of all.. this then presupposes a form of surveillance and control as attentive as that of the head of the family over his household and goods" (p.92), a form of government that became embodied in the patriarchal welfare state.

Veyne (1997) elaborates on Foucault's thoughts on government. He discusses how the act of 'governing' was historically conceptualized in different ways and reflected in the dominant discourses of the times. How one governs will result from how one perceives oneself as 'governor', the act of 'governing' and the 'governed'. In turn the 'governed' will perceive of themselves in ways that correspond to the same discourses by which they are regulated -- an intricate cohesive network of circular reinforcement. Earlier societies had relied mainly on birthright to bring forward their rulers and 'natural order' was the template for ruling. Sovereignty, the resulting mode of government, declared the common welfare of all as its goal. Subjects had to obey laws and respect the established societal hierarchies, which conformed to the order imposed by God unto nature and [men]. Sovereignty was an end in itself; its aim was to ensure people lived within the God decreed, natural laws. Power in this context equalled sovereignty, which had been conferred supernaturally and became embodied by the 'king'. The

elite leaders' duty was to exert authoritarian control by force and punishment through their enforcement agencies, such as the king's army, onto the populace. With the changes that occurred in the industrial societies, Foucault maintained, this form of government based on 'juridical power' of divine justice, and imposed on the governed 'from the outside', became increasingly inadequate and unwieldy to maintain. A modern political economy arose out of the complex, multiple relations between populations, territory and wealth.

Government over time developed into a complex form of power resulting in "a series of governmental apparatuses and a whole complex of savoirs" (Foucault, 1991, p.103). Thereby earlier, more sovereign, state forms became gradually transformed into the administrative, bureaucratic state as societies became 'governmentalized'. 'Governmentality' was defined by Foucault as "the totality of practices by which one can constitute, define, organize, instrumentalize the strategies which individuals in their liberty can have in regards to each other" (Foucault, 1988, p.19). In this context the individual is portrayed as a 'free' agent with rights and responsibilities. At the same time, congruent with the welfare state, s/he is also a 'member of the flock needing to be governed' by a well-meaning guardian. Government's effect on the members of the population therefore had to become 'individualizing' as well as 'totalizing'. Individualization hinges on 'the government of self' and appears as the individuals' own responsibilities. It includes the ethical rationalization of their life conduct, the 'moral' regulation in minute details of their everyday activities and their identities. The overall regulation of society as the aggregate 'economic pastorate' is achieved through the 'totalizing' surveillances of the 'administrative state' -- in Foucauldian terms the 'police' in a broad sense -- which prescribes our activities in every detail.

Foucault, as Gordon (1991) explains, saw government as an activity or practice. 'Art of government' is therefore concerned with "techniques of power or of power / knowledge designed to observe, monitor, shape and control the behaviour of individuals, situated within a range of societal institutions, such as the school, the factory and the prison" (p.4). Society thereby becomes a network of 'omnipresent subjugating power'. The specific strategies conceived and employed around the population's health, and the role of the 'health professionals', will be further discussed under the heading of 'disciplines and pastoral power'. For now I will focus on

the general formations of individuals' subjectivities.

Foucault contended that 'networks of subjugating power' needed to rely heavily on 'self government' of individuals, as opposed to external policing and law enforcement. Of course the latter forms also continue to exist concurrently, less through the application of physical force, but mostly through the 'totalizing' practices of external administration. Self regulation is a very indirect and insidious form of government: the governed individuals become self policing. Surveillance and control are exerted from the inside by themselves and over themselves. In order to appropriately 'self regulate' however, they need first to be 'regulated'. They need to 'learn', within a given society, what are the acceptable choices and behaviours. As was discussed in the last chapter societal relationships, many of which were previously prescribed by the Church, from the 17th century on had become increasingly secularized. They became "progressively governmentalized ..., elaborated, rationalized and centralized in the form of or under the auspices of state institutions" (Foucault, 1982, p.793). The 'state', in that sense, works as a strategy through and within the multitude of societal institutions.

Foucault's 'governmentality', as an 'individualizing' and 'totalizing' force, represents the mechanisms deployed to shape individuals into conformist, productive citizens. Governmentality acts as the major strategy and represents the modern matrix of certain types of individualization, into which people are integrated under the condition "that this individuality would be shaped in a new form and submitted to a set of very specific patterns" (Foucault, 1982, p.783). Individualities are 'reconstructed' through what Foucault calls 'modes of objectivisations'. However, there are always many different mechanisms at work that produce heterogenous effects in how they regulate people's conduct and "way[s] of behaving within a field of possibilities" (p.789). Due to innumerable forces at play simultaneously, many of them unrecognized and obscured, the outcomes can never be predicted. Societal institutions, such as education or the media, serve as the vehicles for the transformation of individuals into sanctioned categories: the 'ideal mother', the 'successful entrepreneur', the 'professional physician', or the 'good nurse'. The 'normalizing discourses shape these specific categories to fit within a given historical context and the 'new' individualities are 'recognized' by their common character traits. Yet there are differences in how they are taken up at the local level and transformed in unexpected ways -- the productive forms



of power. As all discourses always articulate with all neighbouring practices, past and present, shifts in meaning -- what counts as acceptable -- are also ongoing. The moral views of women during Victorian times certainly differ from today's standards, yet some of their influences also persist.

To obtain a 'new individuality' the 'body' of individuals needs to be disciplined in order to achieve "the optimization of its capabilities, the extortion of its forces, the parallel increase of its usefulness and its docility, its integration into systems of efficient and economic controls" (Foucault, 1980, p.135). As it works in and through everyday institutions, such as families and schools, "discipline 'makes' individuals. It is the specific technique of a power that regards individuals both as objects and instruments of its exercise...it is a modest, suspicious power which functions as a calculated, but permanent economy" (Foucault, 1979, p.170). At the same time there is also a 'totalizing force' of classification at work. As a member of a category one is recognized by others and treated and 'administered' in a certain way, at the cost of individual differences. One becomes thereby part of a genre: a nurse, is a nurse, is a nurse... The required mediation of self understanding is achieved by external authorities such as teachers or texts. Subjectivities are formed, are stigmatized and are normalized by disciplinary measures. They are structured through "active self forming subjectification" of individuals as players of "truth games" (Ball, 1990, p.4). Foucault discussed "truth games" as an "ensemble of rules for the production of the truth or procedures leading to a certain result", representing the dominant discourses. Subjectivity and power are closely connected, as power is exercised by "who plays, who says the truth, how is it said and why" (Foucault, 1994, p.16). In this process teachers, themselves previously 'disciplined' by the educational and professional institutions that shaped their own individualities, exercise power by conveying to students what represents appropriate and inappropriate ways of conduct. The categories into which individual students are placed through the measurement of their conducts, in turn, determine how they are perceived and administered. A 'good' student is expected to be successful, a 'bad' student to fail; the mutual expectations created will impact on the student-teacher relationship. Yet, the effects of these technologies are never predictable -- they always contain heterogeneous and unanticipated elements, as power is a 'productive' force.

Foucault (1982) maintained that there are three modes through which the 'objectivisations' of individuals are carried out in our societies. All three seem heavily interrelated. They deal with the (re-)formation of identities of individuals. One of the modes is based on the 'scientific' inquiries, the veridical discourses, that investigate human beings as objects. For example the human 'body' and how it functions is studied through the biological sciences as a 'machine', separate from the mind. The 'mind', on the other hand is examined through psychology; a mind-body dualism is created. The 'labouring subject' is analyzed through economic theories. Within the systems of the multiple scientific discourses in circulation different aspects of individuals are interpreted and reconstructed.

Criteria are used to rate people's behaviours and disciplinary practices shape them towards 'normalization'. Thereby behaviours can be explained, predicted and controlled to an extent within the logic of a particular theoretical framework. Consider for example the 19th century genetic theories that portrayed women as inferior to men. These theories 'explained the reasons' for women's subordination and differences as biologically determined. They 'predicted' the undesirable effects such as infertility, weakness and illness that would result, if women should engage in education and other behaviours unsuitable to their nature. Most women, accepting the 'truth' of these discourses, reconstructed their own identities accordingly as frail and vulnerable creatures. In order to avoid the undesirable consequences they exhibited the appropriate self controls. The genetics theories provided the scientific justification for the exclusion of women from universities and professions and their subordination to men. The discourse was also 'productive' in the sense that it encouraged the development of a whole range of 'womanly virtues', including the Victorian conceptualizations of women as guardians of family and morality, or saviours from barbarism of wars (Stuart, 1999). It also shaped nursing as a supportive and nurturing activity, which helps patients to deal with their life crises and physicians to appear as autonomous, competent professionals (Davies, 1995). Student nurses' unpaid toilings and graduate nurses' underpaid dedication, along with poor working conditions, facilitated the developments of hospitals and healthcare. Their low-cost labour made possible benefits for the public, as well as excesses of other societal groups, such as physicians and hospital administrators.

For Foucault (1982) another mode of 'objectivization' is represented by the 'dividing practices' which also rely on the 'normalizing' discourses. By distinguishing between 'normal' and 'abnormal' they allow us to see individuals as separated 'inside themselves', such as being torn by conflicting desires resulting in indecisiveness and ambivalence, a struggle of one's conscience. Ultimately the manifesting behaviour can then be designated either as 'adaptive' or 'maladaptive'. Some extreme examples here that Foucault mentioned are split / multiple personalities, such as manifested in the Jekyll and Hyde phenomenon. Individuals are also compared / separated between 'self and other', and thereby labelled as either 'mad' or 'sane', 'good' or 'bad'. These binary categorizations, along with the veridical scientific discourses, allow the distinction between truth and falsehood. They define humans against others as what they are not, according to their differences. Members of society know what to expect from and how to respond to each other. As patients, according to specific criteria, we are either diagnosed as sick or healthy. If sick, we take on the 'sick role'. If healthy we are expected to work and to 'act normal'. Every one 'knows' what women and men can do and how they ought to relate to each other in acceptable ways. One of the dangers of the dividing practices is an oversimplification of issues; complexities, the many in-betweens, the multiplicity of forces at play all get glossed over in the process. As all things need to 'fit in' and are subsumed under one of the opposing categories the detailed nuances get lost. For example, people can be 'chronically ill', as defined by their medical diagnoses, yet feel 'healthy'. And gender issues are much more blurred and complex than can be explained simply by labelling them either as masculine or feminine.

The last mode of objectivization Foucault spoke of is about "the way a human being turns himself into a subject" (Foucault, 1982, p.778). Like the first two modes that deal with passive strategies of objectification that go unnoticed, resistance too can surface without awareness. However, this mode also includes what happens when we become aware of ourselves consciously and deliberately choose to behave in situations. Our intentional choices are triggered by a recognition of others' attempts to impinge on the values that are attached to the images we hold of ourselves, our 'self-styling' practices. Here is where we can refuse the imposition of categories in which we do not want to 'fit', hence where the previously discussed 'points of resistance' are

found. Ball (1990, p.4) refers to this mode as “active self forming subjectification”. We, as members of discursively inscribed categories such as ‘men’ or ‘women’, ‘patients’ or ‘nurses’, consciously choose how we do not want to be. As we decide between possibilities of behaviours and characteristics, we become active agents willing to take risks for our chosen ‘truths’ we want to live by. Our ‘self forming subjectification’ occurs within the ‘field of possibilities’ constituted through all the discourses that historically preceded and constructed the social we live in, and that we ourselves are aware of. Amongst the potentials known to us we are accepting and rejecting aspects of our identities.

This mode seems to be the most intriguing one, where some conscious transformation can occur. Foucault stressed not only the ‘discontinuities’ of history, but also allows for some ‘agency’ of individuals in the face of the objectivizing forces that constitute their subjectivities. It is through this mode that our personal differences are shaped despite our common categories, e.g. as nurses, as women. This is why, despite common experiences, we are not cookie cutter copies of each other. Here is where we choose to internalize certain ways of being as opposed to others, where we, as women, as nurses, become aware of ourselves in certain ways and therefore can change ourselves. It is never a total and transparent self awareness, as the Humanists had assumed -- no God’s eye view -- as this would be impossible. Due to the complexities of the social networks and discourses we are involved in, and which impact on how we understand ourselves, many facets of our identities remain forever unknown. Foucault stated that “maybe the target nowadays is not to discover what we are but to refuse what we are” (1982, p.785). Similarly Sawicki (1988, p.186), pointed out that, “the purpose of such consciousness raising would not be to tell us who we are, but rather to free us from certain ways of understanding ourselves...to tell us who we do not have to be and to tell us how we came to think of ourselves in the way we do”.

It is at these points that we can actively shape the parts of our self perceptions that we have become aware of. bell hooks (1989) discussed ‘talking back’ as an example of acts of defiance that she and other black women writers employed. Talking back, “to speak when one was not spoken to was a courageous act -- an act of risk and daring” (p.13). Punishment and ridicule were its consequence. Yet, she explains, the act of speech was for colonized women “the

expression of our movement from object to subject - the liberated voice" (p.16), an example of the productive forces of power on these women's self perceptions. Nightingale's belief that women need male protection and guidance was 'normal' for her time. Yet even then it was not universally accepted by all. Resistance arose in the form of a women's movement toward achieving equality with men. The participants in this movement had become aware of how they had been 'objectivised' and refused aspects of who they had become 'constituted' to be. They reconceived of themselves in different ways, yet necessarily within the constraints of what was known to them at the time, the 'field of possibilities'.

At what point does recognition take place, when do we move from 'object to subject'? For Foucault (1982) we become aware of discrepancies between how we want to be and what is expected of us by others. All reality is always mediated by discourses. As was pointed out in the last section, resistance arises in the face of recognition of three practices: exploitation, domination and subjection. Foucault (1982, p.781) stated that resistance emerges when people ask: "who are we...a refusal of the abstractions of economic and ideological state violence, which ignore who one is individually and a refusal of the scientific or administrative inquisition which determines who one is". Veyne (1997) explains subjection as a consciousness that develops about modes of 'objectivization' by others that until now were taken for granted. It follows the realization about how one has been rendered into and identified as an 'object', a category, ignoring who one is as a 'person'. In other words, people begin to question what is accepted as true and just and who is privileged to say it and impose it on others; they also question the mechanisms by which this 'truth' is imposed.

To increase understanding and awareness societal relationships are traced to their historical beginnings in institutions, not by looking for 'uninterrupted continuities', a history of linear progress, as the 'grand theories' have attempted, but through a 'genealogy'. Barrett (1993, p.133) states that "genealogy seeks to establish not the anticipatory power of meaning but the hazardous play of dominations". One does not go looking for a certain truth but rather is open to surprises one might find. Veyne (1997, p.173) describes genealogy as a "historical analysis of 'natural' objects...a bringing to light of the practice or discourse in question" within their local, historical contexts, and explaining them "on the basis of all the neighbouring practices in which

they are anchored” (p.181). For example, working through ‘male power’ was an effective strategy for women in Victorian times. Instead of categorizing them from our present perspective as passive victims of male domination, female figures, like Bedford-Fenwick and Nightingale, can instead be viewed as active master manipulators. Within the historical context of their times they used effective anarchistic strategies of resistance against male domination, by the means known and available to them.

### **Disciplines and Pastoral Power**

In the literature on professionalism, as discussed earlier, the state had been described largely as an ‘entity’ and ‘professions’ as having developed under its patronage. In modern times, for Foucault, government is distributed amongst, and operates through, ‘diffuse societal institutions’ and their ‘discourses of truth’ specific to the historical contexts. In this conceptualization the ‘professional disciplines’ themselves, as organized ‘institutions’, represent parts of the governing ‘state’ apparatus. Professionals, due to their positions, are seen as agents of social control. As regulators of the population’s conduct they themselves first have to be shaped into effective instruments in order to perform the needed ‘hierarchical observation’. To ensure their citizens’ productivity modern societies became increasingly concerned about the health of their populations (Foucault, 1973).

While sovereign forms of power were exercised by controlling and limiting life, even imposing death, ‘modern’ forms of power were exercised by and enhanced through optimizing health and life. The vitality and health of the population -- a concept launched with modernity -- as an essential resource became an important target and domain of social regulation and intervention. Foucault (1990; 1973) described how, from the 17th century on, political power increasingly dealt with ‘bio-politics as the task of administering life’. Populations were viewed as needing regulation ‘for their own good’ and the health of individuals became an important matter of and for government. Employees of institutions like the educational system and public health held strategic positions and possessed expertise and knowledge related to health of populations and individuals. They began to perform many of the necessary ‘policing’ functions. These measures, implemented through rules and policies and enforced through the authorities of these

administrative apparatuses, allowed for the effective integration of populations into the changing economic systems. Through regulation of their conduct people's lives were directed, at the same time, in individualized ways, deploying a 'power over life'. The goal was to ensure healthy, disciplined populations needed to form a productive workforce. A historical shift in governing had occurred.

Foucault (1990, p.139) discussed how the strategies of this 'power over life' were organized around two poles: The first pole centred on the individual, "the body as a machine: its disciplining, the optimization of its capabilities, the extortion of its forces, the parallel increases of its usefulness and its docility... [through] procedures of power that characterized the disciplines: an anatomo-politics of the human body". The second pole revolved around the regulation of growth and the welfare of the 'species body', society as a whole, "propagation, births and mortality, life expectations...effected through an entire series of interventions and regulatory controls: a bio-politics of the population". Government began to centre around and justify itself with the theme of 'reason of the state', thereby becoming 'rationalized' and 'governmentalized'. The state science of 'statistics' became the major vehicle that determined the necessary regulations. 'Individualizing and totalizing' strategies of self-regulation were organized within the 'normalizing discourses', which were discussed above as arising out of the 'scientific enquiries' and 'dividing practices'. According to Foucault this process was achieved through three strategies which constituted an intricate, complex form of power: "The Christian pastoral, the diplomatic military techniques and lastly the police" (Foucault, 1991, p.104). The traditional tactics of the latter two were reformed and blended in new ways. The goal of these strategies was the achievement of higher standards of 'health' for populations and coincided with the interests of the state in a productive workforce. The resulting concern for the 'common good' was a new notion at the time.

Foucault discussed the strategies health professionals employed in order to promote health, as 'techniques of pastoral power'. This type of power is oriented towards salvation. It refers to the well-meaning attentiveness paid by the 'good shepherd' to the flock. In Christianity originally pastoral power had been concerned with salvation in the next world. It employed confession, a longstanding practice of the Catholic Church, as its major technique. Confession

“implies a knowledge of conscience and an ability to direct it... it is linked to the production of truth, the truth of the individual himself” (Foucault, 1982, p.783). Its purpose is for humans to recognize themselves in certain ways. They thereby compare themselves to societal expectations to learn how they should be and what they need to do in order to achieve salvation. According to Foucault, this ancient Christian institution needed to become secularized and modified. Salvation was now no longer a goal for the ‘next world’ but one to be achieved in this world. It began to take on different meanings, such as “health, wellbeing... security, protection against accidents...we only have to think of the role of medicine and its welfare function assured for a long time by the Catholic and Protestant churches” (p.784).

‘Pastoral power’ also demands a willingness to ‘self sacrifice’ on part of the shepherd for the flock (the calling). Therefore the budding professions had to be concerned with the disciplining of their own members, as was required for this project. To ensure and mediate the necessary self-regulation of individuals there “emerged certain personages, institutions, forms of knowledge: public hygiene, inspectors, social workers, psychologists... Medicine has played the role of the common denominator” (Foucault, 1980, p.62). Acting as instruments of ‘interventions and controls’, health ‘professionals’ as the ‘police’ used the strategies of ‘confession’ or ‘truth telling’ with the population. In recent times these techniques were integrated most obviously in the domain of psychiatry and psychology. However, more or less, they are used by all types of ‘health professionals’, such as physicians, nurses, social workers and even diet counsellors in weight loss programs, to which their customary assessment forms and interviews attest. Patients need to ‘cooperate’ by telling the ‘truth’ about themselves, in order to be directed towards proper self-styling and self-regulation. Individuals are observed, urged, and if necessary constrained by official ‘personages’ (and certainly nurses take part in these processes) for their own good. It is a well monitored mechanism aiming for the individuals’ adjustment to societal expectations and an increase in productivity. This outcome is brought about within the organized and legally sanctioned power relations between health care workers and the population, including coercive measures. Examples are forceful confinement of mentally ill persons against their will and compulsory treatments of people and their contacts with certain infectious diseases, such as tuberculosis, for the ‘greater good’.



Of course, in order to 'govern' effectively, the individualities of the practitioners, as well as their supervisors and professional leaders who represent the disciplines, need themselves first to be shaped into the personages of 'good shepherds'. Their professional identities are achieved through "hierarchical observation and normalizing judgment and their combination that is specific to it, the examination" (Foucault, 1979, p.170), the very mechanisms that are employed by educational and professional bodies. Thereby the disciplines can be regarded as one of the mechanisms through which the necessary 'micro physics of power' are exercised. Goodson and Dowbiggin (1990) discuss how the "professionalization of knowledge into rigidly defined disciplines" (p.105) that took place results in a specific "mode of disciplining self, body, emotions, intellect, behaviours" (p.106). Within their 'regulating practices' disciplines exercise meticulous control in the form of domination of the 'docile bodies' of their own practitioners, who in turn direct the conduct of the public they serve. 'Practices' thereby shape the 'professionals' as well as their 'clients' (Chambon, 1999). Using monopolistic strategies, these institutions continue to legitimize and sanction their produced knowledge through resource allocation, status distribution, career prospects and mechanisms of 'policing', as we have seen in the previous chapters.

The 'regimes of truth' around health facilitate the regulation of a whole network of institutional practices and relationships representing the mechanisms of complex 'hierarchical observations', such as the healthcare system in general and its organized institutions in particular (Foucault, 1973). For the purpose of this thesis I wanted to go beyond analysis and to focus on how nurses can actively help bring about change. Therefore I had to believe that nurses are capable of 'active self formation', by practicing according to ethical standards. Some of Foucault's later thoughts proved helpful, as he too seemed to look for answers about what guides 'human agency'. "Ethics is the deliberate form taken by liberty". It begins with "care for self", one "fits oneself out with truths" (Foucault, 1988, p.5) and follows them -- it also always involves 'care of others'. Self-awareness is a necessary condition in order for liberty to allow for reflective, deliberate practice, which is different from 'moral regulation' by forces from outside the individual. Ethics however is not universally the same; it is always confined within the thought systems of the historical context and guides social conduct (Foucault, 1986; Rose, 2000).

In this sense it is also an act of resistance, as it means the "deliberate practice of liberty". Through ethical conduct we use our strategically advantaged positions in a non-oppressive manner. Strategies should be as open as possible to allow for power reversals. Ethics, the 'deliberate practice of self', "allow[s] these games of power to be played with a minimum of domination" (Foucault, 1988, p.18).

### **Critique and Expansion of Foucault's Ideas**

Using Foucault's ideas on professionalism and power as my conceptual framework will allow, I believe, for a new perspective and analysis of the complexities of the issues involved. Instead of overarching conceptualizations of power, as something held by dominant groups over the marginalized, the instances of resistance at the local level that I hope to discover will be the starting point.

A potential difficulty with this framework might be the lack of strategies of collective resistance, a common critique of Foucault's approach. Is it enough to have multiple unconnected sites where change occurs sporadically at local levels? Or will the 'regimes of truth' which operate in society just continue to go on at the global level, while token concessions are made here and there, yet overall nothing changes? By cautioning us about the dangers in the forever lurking possibilities of new 'totalizing practices' of domination (Diamond & Quinby, 1990), does Foucault hereby render organized political action effectively impossible?

Sawicki (1988) perceives the Foucauldian analysis of power as fitting and useful for women's issues, especially since its focus on specifics allows for the politicization of the 'personal' domain. The 'consciousness raising' that becomes possible through learning from the differences within the groups, and the use of this knowledge to enrich one's politics promises to be a productive method to achieve political goals. However, in addition to local resistance, Sawicki also advocates for concerted action. Therefore she encourages the 'feminist community' to find new ways towards unity amongst themselves, somewhere "between a moralistic dogmatism and a libertarian pluralism" (p.178). Like Foucault she is wary of the totalizing dangers of essentialism and the frequently negative impacts of 'identity politics' as expressed in Richard Sennett's critiques: "...an all or nothing contest of personal legitimacy... powerlessness

comes from the very attempts to define a collective identity instead of defining the common interests of a diverse group of people" (cited in Sawicki, 1980, p.187). The result is that many large scale 'identity politics' get mired in "internal struggles over who really belongs to the community" (p.187), thereby distracting attention from the real issues at hand. The exclusion of working nurses, by the self-proclaimed elite of nursing's leaders, from taking part in designing professional goals is an example of such an internal disagreement as to who has the necessary and appropriate 'knowledge'. It can also be seen as an instance of claims to knowledge by these leaders coinciding with claims to their location and identity as automatic warrants for their ability to 'speak the truth'.

Sawicki concludes that diversities, far from leading to division, provide opportunities for a new, more egalitarian unity: "Perhaps the least dangerous way to discover whether and how specific practices are enslaving or liberating us is not to silence and exclude differences but rather use them to diversify and renegotiate the arena of radical political struggle" (p.190). I too believe that, in addition to the local struggles, uniting around common interests and using our diversities as a rich pool of resources outside of traditional hierarchies will allow nurses to become more effective players in the health care arena. One such common interest, I believe, needing input from all practitioners -- not only the regulating body that currently tries to impose it on all -- should be a reconceptualization of professionalism as an ethical, self-reflective practice within nursing's own 'regime of truth' (Ashley, 1997; Davies, 1995). It should be centred around the question: How can we as nurses play our own power relationships in which we hold 'strategically advantaged positions' vis a vis our patients and other workers with a 'minimum of domination' (Foucault, 1988)?

Awareness can lead toward ethical, less oppressed / oppressive possibilities for nurses' participation in societal power relations. I hope to show that a gap needs to be filled and a more critical look at socialization and professionalism, as they are currently viewed in nursing, is called for. Practising nurses' ideas need to be considered and incorporated in institutional policies. I believe that increased knowledge of power's mechanisms and the processes of identity formation will help nurses to recognize how they themselves participate in their construction, within the context of existing power relations. This recognition should open new possibilities

about how they could and want to 'turn themselves into subjects'. Envisioning how these relationships could be different from what they are, seems to be the first step in constructing new and better strategies and glimpsing alternative possibilities, eventually bringing about desirable changes for nursing and health care.

### **Managerial Science as Veridical Discourse**

In this section I talk about contemporary discourses of restructuring and how they shape / are shaped by governmental strategies and invade local practices. As noted above, Foucault viewed governmentality as the major complex force that traverses society, as the 'conduct of conduct' of society's members. He referred mainly to the welfare state, which was predominant for the most part of the last century, during his own life time. He saw governing of societies in recent times increasingly reliant on 'self regulation' of individuals. Self regulation was induced through benevolent paternalism as 'professional disciplines' guided people to achieve well-being. Lately, however, it seems a change is taking place, as governmental rhetorics become increasingly neo-liberal and bent on 'market oriented' strategies of governing (Greenspun, 2000; Gustafson, 2000). With the shift to market mechanisms more emphasis is now placed on individual responsibility for the population's conduct. Peterson and Lupton (1996, p.10) discuss how the neo-liberal critiques of 'welfarism' have increasingly found favour in the developed countries. "The emphasis on individual and collective entrepreneurialism in health and welfare, and the devolution of responsibility for healthcare and other social services to 'communities' have received widespread endorsement across the political spectrum...". The discourses of traditional bio-politics compete or merge with global discourses which centre around 'deficit reduction' and down sizing of 'big government', a focus which changes how 'society as a whole' is governed. Thereby 'national' discourses seem to get replaced by 'global' ones. Concurrently there is an increasing trend toward privatization, which now invades all areas of public life, including the health care field.

The new veridical discourses are based in managerial science as 'solution' for the 'high cost problems' of societal institutions, such as the health care sector (Guellec, 2001). Greenspun (2000) maintains that current strategies are derived from 'scientific management' theories of the

past, Fordism and post-Fordism, corporate culture of globalization and Japanese management techniques. The keywords are: “efficiency, cost-effectiveness, elimination of duplication, flexibility, clear processes etc. Of particular importance to lean production and flexible specialization is the multi-skilling of workers. Indeed, these keywords of post-Fordist approaches serve as the intellectual grounding and discourse for the new business paradigm in hospital management” (p.28). Societal problems today are to be solved through greater efficiency and better ‘management’ of resources, leading to cost- and deficit-reduction. The patriarchal welfare state had concerned itself with ‘health for all’. The main expectation of the ‘professionals’ involved was to guide people as a ‘flock’ in the manner of ‘good shepherds’. Today the major interest is the bottom line. Institutions are becoming ‘lean and mean’, as market mechanisms rather than the welfare state are relied on to achieve greater prosperity. They are expected to bring about new affluence through economic self-adjustments, as the resulting trickle-down effects create the just right numbers of jobs, paying the just right wages. This form of government does not necessarily mean paying attention to environmental and future concerns to ensure long-term well-being and prosperity, but is mostly focused on immediate economic gains, the bottom line. It requires new technologies of the self, “self-steering mechanisms” (Rose, 2000, p.317) by the players involved, particularly the patients.

In the wake of these changes widespread ‘deskilling’ of nurses’ work has been implemented. Frequently, nurses have been replaced with less qualified and therefore less expensive labour. Picard (2000) states that 51% of nurses have been pushed into part-time positions. A flexible work force, convenient and cheaper for the employer, was created, as staff can be called in or cancelled ‘just-in-time’ (Gustafson, 2000). The multi-skilled generic workers who have taken over many former nursing tasks represent an example of how industrial models of organization, originally designed for manufacturing of goods, are now applied to regulate social services such as health care. These services are measured in units of time, to be bought and sold. Gustafson (2000) discusses the consequences of viewing the time it takes to provide these services as the main commodity. To prevent wasted resources the widespread casualization of healthcare workers, mostly women, was introduced, allowing for flexibility of calling them in or cancelling them on short notice: “By providing just-in-time health care, the institution saves

money on full-time wages and benefits. However, just-in-time health care sacrifices the quality of care and the quality of women's personal and professional lives" (Gustafson, 2000, p.20). An example of time as commodity is the concept of patient care units (PCUs) that are used to determine workloads. This tool relies on translating tasks into numerical units of the time it takes to carry them out. Nursing hours needed get calculated accordingly and staffing is determined. What the tool can not measure, however, are all the interactions that occur between nurses and their patients. Due to the uniqueness of patients and the situations they are in, what is needed to provide 'caring' can not easily be standardized or predicted, hence remains invisible. The clinical approach nurses use to give good care is often in conflict with the cost-efficiency requirements. Nursing care is increasingly hard to do, as it gets lost in the flurry of tasks. If it happens it is more or less a by-product while the prescribed chores are performed, as 'caring is only measured in tasks' (Baines, Evans, & Neysmith, 1991; Peterson & Lupton, 1996).

With fewer services provided a more active participation of subjects in their 'governing' is necessary to achieve health. There is now an emphasis on individuals' own responsibilities for their well-being, be it in regards to economics or health, as cuts to all social services are made. It seems that cost-effectiveness is increasingly brought about at the expense of quality. Healthcare meanwhile is in decline. Fuller (1998, pp.7/8) states: "Healthcare that would serve the needs of Canadians is being replaced by those services that will enhance profits of corporate investors in the health industry". In her eyes, this development in North America is largely a consequence of the free trade agreement. She discusses how 'outsourcing' is a common practice in the hospital sector today. It includes services like dietary, diagnostics and laundry. The increasing reliance by hospitals on city-wide agencies to provide nurses for them can also be considered as outsourcing of nursing services. Many of these agencies are now outbidding each other in hospitals and particularly in homecare, to supply nurses and other healthcare workers. This competition has kept wages in the community well below the hospital-based salaries. As nurses were losing their jobs and few full-time positions remained, new graduates in particular were forced to take any job that was offered to them during the past few years. However now there is a shortage of nurses. It could be expected that the resulting competition to hire healthcare workers might now backfire in favour of nurses -- perhaps creating 'new spaces of freedom'?

The managed care discourse that guided the restructuring of the system is also a discourse of increasing consumer 'choice'. It simultaneously reconstitutes citizens as capable of and responsible for exercising 'regulated freedom'. Bodies are still viewed as machines from the perspective of the discourse of the bio-medical model; but their maintenance now is becoming increasingly the responsibility of the do-it-yourselfers -- the individuals, who own these bodies, and their respective families and communities -- versus the welfare state. To justify political agendas and to bring about solutions, it seems that management discourses are now reorganizing and, at times, even superseding the traditional scientific discourses of bio-politics, as today's salvation is to be found in deficit reduction and profits. It may well be that within the restructured system the most important 'professional' is no longer the physician -- although medicine's knowledge is still considered very important for the common good -- but the efficient manager who, by steering a healthcare institution out of debt, becomes the contemporary hero. Previously patients had been coddled by benevolent experts. It seems an approach of tough love is now used increasingly in an attempt to create the 'docile bodies' that are more willing to shoulder the costs for their own well-being and less demanding of services than in the past. They are thereby becoming 'the patient-as-expert': Individuals now have to assume freedom, responsibility and risk (Peterson & Lupton, 1996), their subjectivities, how they relate to themselves, need to be reshaped.

Therefore I believe it is important to look more closely how these new discourses infuse and colonize practices at the local levels. Understanding their workings and what strategies are used to induce them can point the way to thwart them from within. As managerial science tries to reconceptualize healthcare, for these changes to occur the subjectivities of the players at the local level need to be reshaped. As discussed in the previous section, professionals, as the 'instruments of hierarchical observations' and 'regulators of the population's conduct', always need themselves first to be regulated (Veyne, 1997). They need to accept their own roles to carry out their new functions. Agonisms of strategies at all levels are necessary for successful implementation on the large scale, to bring about the well-monitored adjustment of the populations to the current societal expectations. Health care workers, in the past, were expected to carry out their particular occupations, in part at least for altruistic reasons. It was a 'calling' to

help others, corresponding to their self styling. Nurses in particular were socialized to further the well-being of others, often to the extent of self-sacrifice. To practice effectively within the new mode it is necessary 'to fit themselves out with the new truths' (Foucault, 1988) of the restructured system. Unwillingness to accept these new truths will result in resistance -- 'anti-authority struggles' -- at the worksites. Simola, Heikkinen and Silvonen (1998, p.67), basing their analysis on Foucault's ideas, discuss this process as a "technique of self", the "moral teleology, a mode of ethical fulfillment". As an example they reviewed historical variations introduced into the educational system over the last century. To what extent teaching practices changed each time depended on the teachers' willingness to (re)constitute themselves as "subjects of knowledge and knowing subjects" within the new discourses.

Within the tough love approach of the managerial discourses there seems no room for nurses as caring individuals, who might 'spoil' patients. What is required of them is their expertise in efficient task oriented care provision, to get patients out of the system as soon as possible. These desired goals will be reflected in how the everyday practices at the institutional levels are reorganized. We need to also keep in mind that all discourses always articulate and compete with all the other discourses and practices, past and present. They allow individuals to the extent of their awareness to choose in how they turn themselves into subjects, as practices are always negotiated amongst participants. As the processes are imposing new restrictions simultaneously they also create new possibilities. The diversities among individuals and professional groups exist because they adopt, within 'the field of possibilities', certain 'veridical discourses' and reject others. Thereby they co-construct their subjectivities and use agencies, which makes all social processes so hard to predict.

Various strategies are used to regulate conduct. Smith (1990a, 1990b, 1987) discusses texts as 'objectified knowledge' and 'active agents' of social organization. Printed texts have the ability to reach a wide variety of extra-local sites and to standardize and unify practices -- a property that is tremendously intensified through computerization. As public documents texts regulate and organize 'concerted' actions of individuals at many different localities. However, it has to be remembered that they are the work of individuals or groups and developed at a specific place and point in time, in response to a historical situation. Through widespread application they



become naturalized and fulfill an ideological function. In regards to health care issues, one of the groups helping to produce the texts in healthcare is the current advisory body of the Health Services Restructuring Commission (HSRC). It is an "independent body operating at arm's-length from the government. Its role is to make decisions on restructuring and to advise the Minister of Health on restructuring aspects of Ontario's health services system" (Metro Toronto Restructuring Report, July 1997, p.1). In the conclusion (Appendix G15) of this lengthy document we learn that: the methodology for identification of costs and savings used an approach "consistent with industry practices and methodologies currently in place" and that it developed advice for the Minister of Health "on the expenses and savings estimates associated with HSRC Directions and Recommendations". Even though it concerns itself with the institutions that are responsible for population health, throughout the whole document there is no attempt to disguise its overwhelmingly economic focus.

In attempts to reshape identities within the 'restructuring' discourses new titles and job descriptions are recently cropping up in the nursing literature, as well as in the 'restructured' institutions. Campbell (1992), using Smith's institutional ethnography approach to examine this phenomenon, states: "In Canada, in the 1990s, a business metaphor allows health care officials to apply conventional management solutions, borrowed from business, to health care problems" (p. 763). Within this contemporary discourse nurses and other employees in the sector are no longer seen as mere 'care providers' but increasingly as 'managers of care'. Wood, Bailey & Tilkemeier (1992), agree: 'patient care' is no longer what gets done. Instead it is 'case management' and more recently 'outcomes management'. 'Best practices', as 'discourses of truth', are chosen according to criteria deemed desirable by the institutions of employment and then become the new standard for all employees.

Although managed care approaches are applied in all areas of healthcare, they are most stringently and easily put in place in hospitals with their already existing hierarchical bureaucracy. Lamb, Deber, Naylor and Hastings (1991, p.4), after reviewing the relevant literature, found two stated overall goals of managed care: cost containment and quality of care. Whereas most of the managed care literature focuses on cost containment, which is seen as the primary impetus for its development, the writings on 'case management' often have a greater

'quality of care focus'. A range of its topics may include continuity of care, coordination of care, technical quality of care, prevention of illness and promotion of health, enhanced access to care and enhanced use of the multi-disciplinary team. However, all strategies employed include an aspect of 'down-sizing', in the form of demands for the coordination of a number of services and the 'targeting' of appropriate resources. As allocation of resources is involved, all measures of cost containment also always relate simultaneously to issues of quality of care. The coordination of care at the local level therefore is faced with the challenge of how to integrate financing mechanisms, appropriate utilization management and high quality service delivery. It follows that how the coordination is carried out depends on how 'high quality service' is envisioned and prioritized. To ensure quality of care -- according to the criteria selected -- in managed care systems provisions are made in terms of "structural, process and outcome indicators or targets... Staff and providers are screened to ensure competence" (Lamb et al, 1991, p.32). What gets emphasized and focused on may either be centred primarily on the well-being of clients or on cost containment, which will be reflected in the processes chosen. Also with increasing computerization ongoing evaluation, checking and accounting provides a built-in auditing process.

As stated above, in most managed care systems cost containment seems to be the overriding factor. A survey of 663 hospital chief executive officers revealed that nursing care was ranked by patients, out of 10 factors, as the most important (Prescott, 1993). However Huston (1996) reviewed a number of surveys of hospital administrators. The data showed that administrators would cut staff before limiting capital improvements or restricting research and development. These findings indicate that views of consumers and administrators are at odds. Prescott and Huston further found that between 1980 and 1989 more health care services were produced with less labour. Even though during that time period savings were gained by reducing the number of healthcare workers, there were also increasing costs incurred through intensification of the medical services that were provided. More high tech equipment was used, more tests and expensive treatments were ordered. Their data suggest that procedures and tests were responsible for increasing costs in health care, not human caring provided by health care workers, which is commonly tainted as the main culprit for rising budgets by managements.

To contain health care costs another strategy is utilization management borrowed from scientific management. Its application involves measures to influence the behaviours of users and/or care providers to ensure that care is appropriate and carried out in a timely and cost efficient manner. 'The organization of care delivery is achieved through rules and guidelines, as well as feedback and education (Lamb et al, 1991, p.11). "In theory managed care controls costs by providing health-care services efficiently and controlling utilization to ensure that it is appropriate" (p.27). As 'production efficiency' is the main goal, cost containment is frequently achieved by "substitution of less expensive inputs while still achieving satisfactory outcomes" (pp.28,29), be it in the form of lower paid workers or machines. Overall the numbers of health care workers, especially nurses, to provide human caring have steadily declined, a trend that accelerated within the last few years.

Instruments are developed to monitor the process and to ensure efficiency. They describe expectations and prescribe detailed tasks and behaviours for all concerned, healthcare providers and patients. Some of the strategies used to enforce them may be incentives, others deterrents. At the central position of the hierarchical observation is the case manager who functions mainly as a coordinator of care not as actual provider. A comprehensive background in health care is therefore not always seen as a necessary prerequisite for a case manager; but a knowledge of management strategies is (Davies, 1995). "In theory managed care controls costs by providing health care services efficiently and controlling utilization to ensure that it is appropriate" (Lamb et al, 1991, p.27). The role of the 'case manager' is to weight need, benefit and cost, to come up with the most appropriate service. The desired outcome is 'production efficiency'. This goal recently is accomplished mainly by hiring non-traditional providers for less pay. Another strategy -- much harder to implement, yet probably much more effective -- is proactively to prevent problems or complications. This is where nurses with their knowledge background could direct their energy, thereby simultaneously promoting the patients' quality of life. It is the role of the policy makers to determine the overall benefits to society, usually in economic terms, when promoting particular forms of health care.

One of the instruments to achieve the desired outcomes at the bedside used increasingly in institutional practice is the 'care map'. It is a tool that clearly prescribes what needs to get

done, by whom and when. Goode (1995) discussed how it was introduced to reduce costs and improve efficiency outcomes of care. It thereby seems to encompass all the goals of managed care. The major interventions for the key healthcare providers, such as physicians and nurses, are 'laid out in regards to timing, sequencing and length and structured around intermediate goals and outcome criteria' (p.338). Patients too get a copy of the care map, so they know what is expected of them. Their willingness to become active collaborators is needed for their effective self government. The case managers, who are often but not always nurses, occupy an elevated position. They coordinate the care provided by monitoring the patients' progress and making sure that all participants stay on the care map and meet outcomes. They also educate participants regarding use of the map and analyze process and outcome variances. Their position allows them to exercise surveillance and control over all to ensure that efficient delivery of care and desired outcomes are achieved. They therefore play a central part as 'police' in this process.

The care map, as a new management tool, possesses statistical features to provide continuous quality assurance; increasing computerization of data makes the constant monitoring of all participants a potential reality. Built into care maps it is, once again, the documentation of events and performance that gets assessed. Documents are much more convenient to access and evaluate than reliance on direct data, such as patients' own accounts of the care they received. However these processes construct a picture that often does not correspond to the lived experience of the clients and practitioners but speaks a 'textual reality' that articulates with the overall organizational management system, giving the appearance of efficiency.

The major risk that arises from the managed care discourse is that of underservicing clients (Guellec, 2001). Due to economic incentives the public's utilization of services might be curtailed, since an inherent tension exists for the healthcare workers involved between loyalty to patients and their best interests, on the one hand, and loyalty to the organizational objective on the other. Guided by the desire for efficiency, the most cost-effective practice, such as the shortest length of stay, might become the desired standard to be achieved, to the exclusion of other criteria. This is a particular danger when the case manager does not have the broad background in health care necessary to recognize what is important and what can be let go. Sturm (1998), a management consultant, describes hospitals as 'commodities' within managed care. He

advocates for vigorous marketing strategies in today's competitive healthcare environment. Advertising one's particular 'brand' of health care which could include alternative medicine, supporting one's successes with 'proofs', and keeping costs low are strategies he recommends.

Lamb et al (1991) warn that along with entrepreneurialism, the emphasis might shift too far towards marketing and amenities, away from quality. Thereby advertising could replace quality assurance. Current advertisements extolling the wonderful effects of Laser eye surgery seem to bear this out. Yet a lack of regulation exists, resulting in often inferior and sometimes harmful procedures. Recent news reports increasingly indicate that in some cases vision actually worsened after the procedure and that side effects may include night-blindness that progresses further with age. In the field of service provision relying on advertisements is increasingly a possibility. As the prevailing worldview in healthcare continues to rely on the quantitative form of assessment, qualitative methods to measure the effects of caring practices need to be recognized.

Despite the dilemmas that this approach might pose, Nursing Case Management (NCM) is widely accepted. It is regarded as a form of 'advanced nursing practice'. Its proponents are convinced that through 'evidence-based practices', the nurse case manager will find ways to reconcile diverging interests between quality care and cost-efficiency. In a recent literature review J.E. Smith (1998, p.102) concluded optimistically that "case management can lead to prevention of costly complications, the reduction of duplication and gaps in services, stronger informal support networks, and clients who manage their own care". No mention is made of client satisfaction with the care received. On closer examination it seems that these factors relate to better coordination of services -- no doubt necessary and desirable -- but they can not become a replacement for nursing care itself.

### **Some Critical Perspectives on Managed Care in Nursing**

From a more critical perspective Campbell (1992) expresses doubts that nursing professionalism will be accomplished by nurses becoming case managers, a position that some seem to view as a form of 'advanced practice'. She discusses how this "new standpoint of cost-efficiency that subordinates nurses' traditional interests and grounding of their work in the

standpoint of care" (p.751) is inherently problematic for nurses. "The technologies, such as computerization, transform nursing decision-making into information-based practices, comparing records of nursing care to the written standards". Quality of care is thereby addressed through "a management technology, in a set of technical steps" (p.755) and achieved by "managing nursing technologically" (p.759). How nurses practice is regulated by implementation of protocols, aimed at controlling the quality as well as the cost-efficiency of nursing care. The 'quality indicators' consist of measurable factors, like timeliness and technical accuracy, thereby reducing nursing services to tasks carried out. 'Caring practices' are not readily quantified and hence can not be measured directly. The essence of nursing -- what takes place in the 'nurse-person interaction' -- is thereby easily overlooked and discarded. Nurses themselves and other personnel in the process become "resources to be managed effectively" (Campbell, 1992, p.763). This approach is based in a management, not a nursing perspective. Carried out in hierarchical institutions, they rely heavily on the textual reality of documentation to communicate between the multiple layers. Davies (1995) reports that similar processes had been introduced into the British health care system. She too maintains that these types of bureaucratic organization are alien to nurses' own perceptions of their work. Further she claims that "the system fails nursing, insofar as the conditions for its practice and its proper development have never been put in place" (p.102). Nurses in case management positions are trapped in roles supervising others that do hands-on care, while they themselves have only 'fleeting encounters' with their patients in an effort "to make the Polo mint work" (Davies, 1995, p.102). The actual practice of nursing, which requires sustained encounters for trusting relationships to develop, thereby never has a chance to get off the ground. Davies refers to this dilemma as the 'Polo mint problem', "the fact that the practitioner role [in hospitals] is not there and that nursing must always be accomplished with a variable and transient labour force" (p.102). The central task of nursing is therefore reduced to manage this labour force and to get the work done safely.

Padgett (1998) examined the contradictions and tensions between 'client goals and systems goals' inherent in this framework. He too perceives managed care as rooted in a corporate management view -- a perspective that favours 'systems goals' by its nature. Therefore role conflicts and ethical challenges tend to result for nurses in case management. He states that,

'rather than providing a resolution of the dilemmas of caring, however, NCM can be seen as an embrace of much that is problematic for nursing...the 'health care wars' writ small: the disputes over goals and roles, methods and meanings, privileges and priorities" (pp.10,11). The nurse case manager tends to be caught in the middle. Therefore, Padgett claims, NCM is most likely neither the vehicle to advance professional nursing and its goals, nor to achieve greater influence in the system. Nor does he see it as the avenue to reverse the current trends of indiscriminate cutbacks. The problems of defining, providing, and achieving quality health care can not be resolved by management techniques alone. He encourages nurses and clients "in challenging corporate managed care, and in revisioning the goals of client empowerment, care coordination, and system redesign from more emancipatory perspectives" (p.11). Similar suggestions are featured in Guellec's (2001) commentary to turn the system around.

I agree with the authors above that quality of care and cost-efficiency are two very different and often contradictory goals. An ongoing tension exists between them. In the present political climate efficiency is more likely to outweigh quality. However, the space to focus on quality of care -- a space of freedom perhaps? -- exists within the discourse, hence it should be possible to achieve it 'from within'. In the nursing literature in which patients are discussed as the central figures, their individualized, unique needs determine how services are to be provided. The nurse holds the key role, since s/he is the one who is concerned with the 'whole' person. The nurse's contribution is seen less as 'managing' and more as 'ensuring quality of life' for the person and to represent his/her wishes and interests with the 'team' (Cody, 1994; Jonas-Simpson, 1996). When striving for 'quality of care' the challenge is to show that efficiency is not compromised. Hence the quality indicators would most likely be patient and care giver's satisfaction, as well as data on decreased morbidity and mortality. In the long term cost efficiency should be achieved, as nurses will have less sick time, are less likely to quit and in general provide better quality care for patients. Patients who are well cared for should show faster recovery rates and fewer relapses hence, if all things are considered, saving the health care system money. The difficulty is to represent these effects as 'visible' outcomes. As they do not lend themselves readily to immediate measurements their connections to each other are harder to 'prove'.

Curtin (1996, p.304) states that, as early as 1986, research had shown that for patient care, "the best person to do the job is a well-prepared nurse working in an empowered and respectful atmosphere...quality of nursing care was the most important factor affecting the survival rate of patients admitted to intensive care units". She further elaborates how, in the best hospitals, the nurses had protocols that allowed them to make minute-to-minute changes within defined limits. They were involved in planning of how many elective surgery patients could safely be cared for and had good relationships with the physicians they worked with. In the worst hospitals, those with highest mortality rates, the nurses were ordered to care for more patients than they felt they could safely look after, they had little autonomy and poor relationships with their medical co-workers. She concludes that "hospital restructuring, reengineering and redesign WORK, and work well, only when nurses are enabled to practice and to practice well" (p.307).

### Summary

In this thesis I am exploring how hospital nurses perceive of themselves as nurses within the restructured system and how they, with other players, actively participate in the practices of healthcare. I am also looking for possibilities to (re)value nursing and to bring about effective changes that improve quality of life for patients and quality of worklife for nurses. Foucault's conceptualizations of power and subjectivity seem to me a fitting framework for this project. Power is treated not only as a prohibitive, but also a productive force. It traverses all societal networks, manifests itself in everyday practices and is also inherently unstable. Foucault's method calls for exploration of power's heterogeneous effects beginning at the points where they are actually played out, the 'local levels', such as the bedside. It is more exploratory than predictive, rendering the taken-for-granted visible. His perspective on societal relationships and the strategies used to maintain them -- but also those exercised to resist from 'the inside' -- can provide new insights.

Power is induced into individuals' bodies through micro-capillary relationships, such as those between the groups that interact with each other in a hospital ward. It is put into action when members play their strategic games, which then create and maintain the institutional hierarchies amongst nurses' own ranks, between nurses and patients, nurses and other healthcare



workers and nurses and administrators. Power in healthcare is closely associated with 'discursive practices' that represent medical knowledge and managerial knowledge as the 'discourses of truth'. Nursing knowledge, subordinated to medicine, gets thereby 'blocked out' and remains invisible. Discourses contain the 'assembly of rules' for the actions of the various groups and their relationships to each other. Societal institutions, like the healthcare system, are conceptualized as blocks of power which always also articulate with and build on all the other establishments within a society, such as roles of men and women, educational systems and government. Shifts in power occur constantly and simultaneously within the social nexus, such as those brought about by the women's movement, effecting changes across all levels of societies. By necessity, everyone in a hospital, be it as patient or worker, is always participating in multiple relationships. Although all relationships produced are always unequal, they are also unstable. Dispersed within everyday operations, power relations also make possible multiple strategies of resistance that can be organized at various points. Therefore effective change comes best from within, not from above. Foucault maintains that resistance is power's *raison d'être* -- without it power does not need to exist -- and freedom to act is the necessary prerequisite. Once power's workings are understood a counter discourse can be created, using the elements of the original discourse, to redefine practices.

Foucault contended that contemporary government is achieved mainly through individuals' self regulation. Professionals, responsible to provide guidance to and expected to gain compliance from the ones they serve, need therefore first to be effectively socialized themselves. The requirement to pass 'examinations' within their disciplines ensures that they know to distinguish between what the dominant discourses proclaim as right and wrong, sane and sick, and the processes of 'normalization'. Subjection of all societal members is achieved through the specific scientific discourses that are perceived 'true' at the time. Further there are also the 'dividing practices' that tell the players how they distinguish themselves and are thought of by others. Usually we are unaware of these mechanisms and take them for granted. Lastly there is active 'self formation', what individuals themselves see as their desired conduct as ethical individuals. When different from what the dominant discourses prescribe, individuals become self aware. Therefore I will examine the data of how the participants perceive of

themselves as nurses in light of these mechanisms, particularly the latter. Resistance is a response to individuals' recognition of their exploitation, domination and subjection -- an imposed identity that conflicts with their own ideas of ethical self formation. The resulting struggles are localized and anarchistic. Tracing resistance back to the veridical discourses that brought them forth exposes them and points to change from within, yet always within the confines of the historical field of possibilities, representing what is known and knowable.

It seems that the 'managerial science' perspective has slowly begun to transform the thinking and practice of healthcare workers and the public. Population health and the individualized guidance of sick individuals lately are closely associated with economics and fiscal responsibilities. The efficient manager is today's hero. The primary concern is now the bottom line. Individuals are expected to be more responsible for their own health and receive less assistance from governments -- a 'do-it-yourself approach' to health. Restructuring represents the effects of these discourses at the local level -- how they reorganize the jobs and lives of healthcare workers and patients. They are made possible and put into action through the relationships of the players with each other. As all power strategies are always unstable and 'exceptional', once awareness is raised and other possibilities envisioned, change through resistance can be brought about.

The following chapter deals with the research design. The design was chosen to fit the research questions and to be congruent with the conceptual framework. It allows for examination of practices at the local level. The original research plan and the actual process, as it evolved, are described.

## **CHAPTER 4**

### **RESEARCH DESIGN**

#### **Introduction**

In this chapter I discuss the methodology for the data collection and analysis. It is an attempt at creating an 'audit trail' to ensure 'confirmability' of my findings (Streubert & Carpenter, 1999). I begin with the theoretical arguments for the methods used and then describe the actual process and changes made -- some due to external happenings beyond my control and others that emerged in the course of events, as they appeared more favourable and appropriate for the purpose of the study. The chapter ends with the demographics and profiles of the participants, a brief discussion of the significance of the research and the process and organization of the data analysis.

#### **Phenomenon of Concern**

As stated in the title, the phenomenon of concern in this project is how bedside nurses perceive nursing in the context of restructuring. This study tries to bring to the surface the effects of discourses of 'restructuring', how these discourses reorganize institutional practices and relationships at the bedside, as seen from the perspective of nurses. I am exploring how the nurses think of themselves and their work and how they co-create their position within the present context, thereby participating in the relationships of power. To envision alternative strategies which can effectively improve health care practices and working conditions, I believe we need to consider the ideas and experiences of the frontline workers. We also need awareness about the mechanisms by which the nurses' perceptions about themselves and their practice are shaped historically and in the present, and to demystify some of the 'knowledge' that shapes these issues. Foucault states that all knowledge is always 'subjugated' and 'colonized' by discourses, which produce its meanings. So far the experiences of the practicing nurses have been largely missing from the ongoing discussion about the discipline, as nursing's practice was, and continues to be, designed almost exclusively by its scholars and leaders, other professionals and the politics of the day.

Foucault suggested that we analyze institutions, not by starting with the power relations embodied within them, but with 'the play of strategies employed' at the 'local level' of the everyday world. Foucault's method consists of examining the ordinary meticulously. This means looking at practices as the mechanisms through which power works and becomes visible. The bedside is one site where restructuring takes effect and thereby impacts on the lives and work of nurses. Listening to the nurses' perceptions and stories seems an appropriate way to learn about institutional practices. Chambon (1999, p. 59) claims that Foucault himself studied power through detailed accounts "of experienced self and particularly of *embodied* self -- the multiple imprints that institutions make on our bodies". It requires a qualitative method of analysis that is flexible and sensitive to specifics as they exist at the micro-level. Power relations, according to Foucault, become most visible at the 'points of resistance'. With the Foucauldian concepts of power/resistance an utopian reversal of the overall situation does not need to occur before desired change can be brought about. Resistance as a 'self styling' practice arises from an awareness of the until now taken-for-granted, a recognition of one's unequal position within the existing power relations. It might be directed against feeling exploited, dominated or subjected in a way 'one does not want to be'. It can lead to a re-conceptualization of self from 'choices within a field of possibilities' of discursive practices at the time.

The focus of my inquiry is the working world of the practitioners at the bedside, where nursing happens. Starting at this point, where discourses colonize and transform the individuals' actions, we can look at strategies for change. Inevitably bedside nurses intentionally and unintentionally participate in institutional power relationships. Listening to their experiences should bring in new perspectives. Their accounts, I hope, can provide a deeper understanding of the discourses of the restructuring processes and the mechanisms of identity formation that help make restructuring possible. The general background of the historical and contemporary contexts in which the nursing occupation, along with the medical profession, developed was provided in chapter two. The specific hegemonic discourse of managed care, arising from managerial science, was discussed at the end of the last chapter. Tracing practices to past and present discourses, I hope, will help to bring the data into clearer focus. The findings have implications for the professionalization of nursing, its education and practice. I reason that the insights gained

will contribute to the development or expansion of strategies, such as how to emphasize 'quality of care', based in the needs and well-being of the patient. (Re)valuing caring should also further the quality of work and worklife for nurses and increase occupational satisfaction. In the end it should lead towards improved healthcare, based in a knowledge base and work ethic specific to nursing. The first task is to raise awareness about the taken-for-granted and thereby to open up the 'field of possibilities' in which choices can be made.

### **Methodology**

A qualitative, descriptive and interpretive approach (Bogdan & Biklen, 1992; Ely, Anzul, Friedman, Garner & McCormack Steinmetz, 1991; Tesch, 1990; Lincoln & Guba, 1985) seemed appropriate to explore nurses' perceptions about themselves, nursing and their thoughts on 'restructuring'. Bogdan and Biklen (1992) state that qualitative research occurs, not in a laboratory, but in a natural setting as the data source. Mishler (1986) asserts that it therefore avoids the distortion and reification that occurs when phenomena are investigated in a 'context free', artificially created environment. The researcher is the key data-collection instrument. S/he describes and analyzes. The concern is with the process -- what has transpired -- as much as with the product or outcome. Data are analyzed inductively by 'putting the pieces together'. Silverman (1993) maintains that these type of data are always inherently problematic and need to be analyzed, as they are "never simply raw, but situated and textual" (p.199). Finally this type of research is about the meaning of what is discovered, the why as well as the what. Therefore it is not about testing the truth or falsehood of a hypothesis. The inquiry is concerned with learning more about fellow human beings (Ely et al, 1991). It is utilized in order to explore the participants' 'multiple truths' (Morse, 1991; Rolfe, 2000; Streubert & Carpenter, 1999), to describe, explain and help change the world in which we live (Kirby & McKenna, 1989), and to act as a search for unity amongst diversity of findings (Ely et al, 1991; Morse, 1991; Rolfe, 2000). These goals are achieved through multiple comparisons of the participants' statements to each other.

In this study, through the 'accounts' of nurses who practice at the bedside insights are sought into their everyday world, in which they work. Ely et al (1991, p.196) state that "research,

like all other knowing, is a transactional process -- the knower and the known both act upon each other". The authors go on to describe how the presence of the researcher introduces a 'reflective mode' which compels the participants to examine and change their own actions. A setting will be altered always through the reflective process alone. "People who have never before articulated their beliefs and practices now are asked to do so" (p.197). Therefore topics become verbally objectified and can be examined -- the familiar and taken-for-granted has now surfaced into conscious awareness. Sreubert and Carpenter (2000) discuss this as a dialogical process of the 'self-understanding person' with who or what is encountered. Unlike in quantitative research where 'objectivity' is the goal, the authors encourage us to 'embrace subjectivity' and to examine its effects "on the research endeavour and description of the phenomena under study" (p.10).

In this project the reflective mode was important, to stimulate increased self awareness. It became especially apparent when the participants ponder their personal philosophies and beliefs in relation to their practice. There were pauses, thoughtful looks on their faces and many 'mhm-s' and 'ah-s' accompanied their answers. To encourage the reflective mode I had chosen a semi-structured interview guide that kept the focus on the topics, yet still allowed the participants to elaborate their own thoughts and relating their own stories, when and where ever they wished. The social organization of their working world, how they understood it and how they increased their awareness, was portrayed in how they described and explained their experiences. Often they would, during the interview conversations, make statements like: "You know I never thought of that before", or "I never thought of it in that way", especially on the topics of their own values.

I believe that my interviews are an appropriate format to explore nurses' perceptions of their occupational identities in the present context, which are rooted in a past and contain their envisioned future of nursing. I kept in mind that, as "meanings in discourse are neither singular, nor fixed, and that language is indexical, hence what is meant has to be investigated" (Mishler, 1986, pp.64-5), my own perception/ interpretation might differ from the participants'. Therefore, to get the participants' own viewpoints with minimum imposition of my own interpretations during the data collection, probes were used, as needed, for clarification. I also validated participants' meanings during and after the interviews as much as possible with them, by restating what they said and asking for needed clarification. As mentioned above, the process of

the interview itself will have changed the meaning. By adding new insights, it will have created a 'deferred meaning' (Derrida, 1981). Change is ongoing and the same thought can never be produced in exactly the same way. The data represent snapshots of how my participants perceived of themselves as nurses and nursing in the context of the restructuring process, at a particular point in time (Morse, 1991), but then are (re)interpreted during the process from the perspective at the time of the interview.

In a recent research seminar I attended, Dr. Adrienne Chambon (Chambon, 2000) discussed research within the medium of the arts. She believes that different layers can be uncovered with qualitative methods using Foucault's insights with his focus on context. One might look at a painting and what it represents. But this is the surface layer only. Below it are many underlying social practices that are rooted in discourses that helped produce and are reflected in the painting. They can be revealed as the layers are slowly peeled away -- like those of an onion -- by locating the historical contexts of the event that is represented, as well as when the artist created it. The painting then can be appreciated in its forever more complex embeddedness. As I began my interviews and data analysis the snapshots of the participants' accounts of their restructured working world exposed themselves as the top layer, promising that there was more underneath. They showed the effects that were on the surface and how the nurses tried to cope with them in the restructured system: the staff shortage, lay-off survivor syndrome, the workloads, changes in staffing and such. This outside layer represents their relationships with the system itself, as they were reshaped by the new discourses of 'managerial science'. Their redescribed roles were revealed in their accounts of the experience of restructuring, mainly during the first part of my questions (see Appendix B: Interview guide), which will be discussed below in more detail.

I then tried to dig down into what lies below the surface, the deeper layers to uncover some of the processes that are less obvious, but nevertheless are the driving forces for the nurses' understandings and actions. These are the processes that have to do with humans as subjects and their self interpretations; how they, within the social context, co-construct their subjectivities in interactions with others. It is about their assigned places in the hierarchies of power relations, and about the dividing practices, that impact on their actions. They are formed and internalized in the

relationships with others they encounter in their work. The questions about relationships brought to light some insights but also some taken-for-granted assumptions that remained unrecognized to the speakers. These unchallenged assumptions tended to be concerned with longstanding traditions, particularly between physicians and nurses, which had been 'naturalized'.

Lastly I explored the relationships the nurses have with themselves, their self-styling practices. Here, refusals to accept societal impositions which are incongruent with their own ideas of how they want to be as nurses, inform their attitudes and become diverse acts of resistance. As anticipated I found deviant thoughts and practices at the points where nurses felt strongly about how identities were imposed on them by others. They became aware that they were treated as objects of exploitation, domination and subjection when their desired practices were interfered with. These awarenesses tended to be most apparent in the areas of patient care, whenever their own ideals were thwarted. However there are also some areas that remained unexamined and unquestioned. For the data analysis it was helpful to refer back to the past and present discourses in which the nursing practices and relationships are embedded, as discussed in the earlier chapters.

The format chosen for the data collection was the one-to-one interview. As some of the statements were sensitive in regards to employers and institutions this mode best ensures anonymity. When I was recruiting I made it an option for participants to come together as a dyad or group. However nobody ever asked for a joint interview with others -- perhaps one more indication of the insecurities that the restructuring had created, producing mistrust even amongst co-workers. The interview questions were treated as guides and asked in a manner as open-ended as possible (see Appendix B). Participants were encouraged to relate examples and tell 'stories' to elaborate their meanings. Storytelling allows for a natural flow of thought on part of the interviewee. This particular format was chosen because the topics in these types of interviews tend to be 'contextual rather than abstract' (Paget, 1983). Polkinghorne (1988) too maintains that human experience is always enveloped by the personal and cultural realms of non-material meaning and thought. It is therefore also never static but continuously (re)configured by new experiences and reconceptualizations.

Stories are lived before told. Story-telling is seen as "a significant way for individuals to



give meaning to and express their understanding of their experiences" (Polkinghorne, 1988, p.35). They allow us to "interpret past experiences within present context and anticipated future" (p.36). Yet it has to be remembered that they emerge within the discursive scaffolds we choose. Story-telling seems able to capture Foucault's conceptions of continuous change. The purpose of these types of research is not to find a 'true meaning' that is unalterable, but a meaning that sheds light at a particular point in time about a particular person in the context of his/her life experiences. As explained previously, reflecting back this 'truth' might now be explained in light of new experiences that had since added new learning and understanding. Foucauldian inquiry, as well as the nature of my research questions, demanded close attention to context. Narratives are also capable of responding to the nuances of the mood and the content of the evolving conversation, hence are dynamic and interactionally sensitive. Emotions of sadness, pride, anger, joy and resentment were displayed in the course of the interviews by the participants.

When interacting with nurses during recruitment for the study I always made clear my interest and passion for nursing. However, during the dialogues, in order to reduce my own impact as interviewer I refrained, as best I could, from showing my own emotions regarding their tales and assertions. I was attentive and tried to convey interest in what they said. At the same time I checked my facial expressions and body language as much as possible not to betray my own emotions about the issues discussed. To accurately reflect the interviewees' ideas, to increase 'rigor' and 'reliability' (Ely et al, 1991; Rolfe, 2000) or 'trustworthiness' of the data (Streubert & Carpenter, 1999) I tried to keep my own opinions out. Therefore I stayed away from using probes that would reveal my own thoughts in response to their stories. Even though "interviews are jointly produced discourse" (Mishler, 1986, p.43), with the open questions of a narrative format there is much less intentional construction of data than in a typical survey-type questioning of the respondents, in which one uses carefully defined wording to obtain specific information to avoid ambiguity.

Brink (1991, p.168) cautions that respondents will gear their answers to what they think is either "a) social desirability in which research subjects respond with what they believe is the preferred social response whether or not it is true; and b) acquiescent response set in which

subjects consistently agree or disagree with the questions. Any questionnaire or interview that elicits agreement or disagreement with the interviewer is subject to this type of error'. Therefore questions should be constructed to avoid this type of responses. People want to look good and often do not like to admit to their own flaws, even to themselves. My questions about participants' ideas of the ideal nurse and nursing practice tried to encourage self-reflection on these issues. Seeking "already socially desirable responses", I attempted to circumvent deliberate misrepresentation of data that the speakers might fear would make them appear in an unfavourable light. The open-ended "grand-tour and inclusive questions" used, I hope, avoided an "acquiescent response set" (Brink, 1991, p.169). As Brink notes, when open types of questions are asked, these errors are not usually a problem in qualitative studies. Similarly Lipson (1991, p.73) suggests that through 'open interviews' researchers tend to "minimize manipulation of research subjects [and] limit a priori analysis or definitions of variables...". In Foucauldian, terms through these approaches more egalitarian relationships of power can be developed, therefore minimizing resistance of the participants which could be expressed by withholding important or insightful data or by deliberately lying. During the data collection I noticed that my participants reported the 'socially undesirable' behaviours in two ways: they were related either as behaviours of 'others', or in the form of their own experiences as 'victims' rather than perpetrators.

As the only interviewer, I audio-taped all of the sessions and afterwards transcribed them myself. When coding I employed the participants' own words as categories in the first level of analysis, using them as concrete 'micro-codes' before moving up to abstract 'macro-concepts', "as macro-theories derive from micro-data" (Hutchinson & Webb, 1991, p.318). As an example when participants talked about 'having no voice' and 'sitting on the sidelines' it was subsequently interpreted as devaluation and marginalization within the system. I also kept observational field notes which were useful later to help reconstruct details of context. These notes were written as soon as possible after the interviews, as I found it too distracting to write during the event, when I wanted to focus my whole attention on what was being said and how. Playing the tapes over also brought back the actual experience quite vividly as emotions were conveyed in the tone of voice, laughter, fluency of speech and hesitations -- all the different

nuances through which meaning is conveyed in the process of conversation. It was hard to predict beforehand when a 'point of saturation' (Lincoln & Guba, 1985) would be reached, meaning that little new information would be obtained by additional interviews. I had planned on listening to twenty nurses, but kept in mind that the numbers might need to be increased. However, as it turned out, I believe I had sufficient information at the end of these interviews. Apart from the more personal specifics of each individual nurse, no new major themes emerged. However I agree with Morse (1991), who cautions that due to the myriad of variations of individual experiences, dependent on context, the 'point of saturation' is always an artificial one. She maintains that, as change is ongoing, new meanings will forever emerge. Therefore it is solely at the discretion of the researcher to "decide whether or not the new information is significant" (p. 141) for the purpose of the study. The main criteria here was a temporal one: I focused on snapshots of perceptions and practices of nursing related to me by twenty participants, during several months, within the context they occurred.

### **Interview Questions**

My research questions were: What does the restructuring process look like at the bedside where it is transformed into actions? How do the changes impact on nurses' perceptions of themselves and the quality of their work lives? What are the nurses' perceptions of their own roles and of the relationships that they have with others in the system? How do nurses themselves participate, knowingly / unknowingly, in the relations of power that bring about restructuring and shape their positions? What are the discourses behind the processes that reorganize institutional work and relationships? How do they impact on nurses' subjectivities and work lives? What are the participants' ideals of nursing? Which changes are accepted and embraced? Which ones are resisted and how? What strategies could be used to (re)value nursing? How could the nurses actively participate in bringing about changes that promote their patients' quality of life and their own quality of work life? More broadly speaking these questions are concerned with how the discourses of restructuring impact on nurses' subjectivities and thereby co-create the institutional practices and relationships at the local level, but also explore possibilities for change. Using Foucault's ideas on power/resistance and subjectivity as my conceptual framework, I investigated

these phenomena by asking bedside nurses about their perceptions of themselves and their work within the present context of restructuring. I also explored their ideas about their relationships with others and what they believe is ethical nursing practice.

To obtain data on specific topics, yet without limiting the range of responses, May (1991, p.192) believes it is important to maintain a balance "between flexibility and consistency in data collection". Throughout the interviews I covered the same topics. To maintain consistency May (p.194) suggests that "enough details in their [participants'] stories that the investigators can compare their major elements" are needed. I was flexible, however, as to when and to what detail, participants chose to discuss certain aspects -- I went with the natural flow of the conversation. In the end I was making sure that the topics had all been covered, asking questions if an area had been left out. To reduce the extent of my own previous knowledge colouring my understanding of the interviewees' perspectives and to minimize "topic control through the wording of interview questions" (p.196) I used, as May advises, open ended prompts and non-specific language. I treated the early interviews more as 'open conversations' to get a feel for the participants' worldview. Afterwards, May suggests, to make sure that the important points then are covered with as many participants as possible. For initial categorizations I depended on the interviewees' own words. As themes started to emerge, such as the issue of how new nurses are treated and viewed by the 'old' nurses -- participants described nurses repeatedly as 'eating their young' -- my probes tended to become more directive. I would, for example, ask about what they thought of the educational preparation of new graduates today.

Guided by the research questions my interview questions (Appendix B) were formulated. I began with inquiries regarding demographics: length of time in nursing, educational and employment histories, gender, age, cultural/ ethnic/ racial self identification, professional/ occupational memberships. To get at the participants' perceptions of nursing within the present context, I started by asking about their experiences with restructuring and its impact on their work. This issue, I anticipated, would be foremost on the participants' minds and therefore a good warm-up question. How had it changed their practice? How had their role changed as a result of it? Some described typical working days / shifts, using narratives of their concrete experiences. Many different scenarios were recalled to illustrate some of the points they wanted

to make. I asked about their own ideas of restructuring: what works, what does not, why and how they themselves would 'restructure' if they had a say. I obtained many thoughtful and practical suggestions that illustrate their everyday understanding of how things work.

Another question I posed addressed their work relationships with others: their patients and the patients' families, the public, co-workers, other nurses, other health care workers, administration. I wanted to find out how they locate themselves in relation to the other players within the health care arena, and how their relationships with them are (re)negotiated as a result of restructuring. Learning about their perspectives I believe has shed light on how the institutional relationships as 'dividing practices' have been reorganized and how the players participate/ resist, knowingly and unknowingly, in the 'agonisms and antagonisms of strategies'. In order to learn about their ideas of 'socially desirable nurses', how they would like to be and practice, was explored: I asked about their images of a 'good nurse' and their ideals of nursing. By comparing these ideals to their actual experiences I wanted to bring out any discrepancies between what they thought should be and what happened. The 'actual' that was unfavourable was mostly related in terms of actions and attitudes of others, or their own victimization. Whether their views on nursing changed and why, over the course of their careers, and what they need to stay / become the ideal nurse they are / would like to be was explored. I also probed their (personal) philosophies that guide their practice. These types of questions were designed to stimulate their reflections on 'self-styling practices'.

For the group of nurses who worked with patient-focused care, there was an additional question regarding their ideas on practice based in this philosophy. I thereby tried to explore if an institutionally supported nursing theory does make a difference to the quality of life for patients as well as nurses, thereby acting as a 'counter discourse' to managerial science. Other topics explored were nursing's future, universal degree preparation as entry to practice, the current professional status of nursing and what professionalism should look like. During the time I collected most of the data the nurses in Quebec were taking job action. The participants' views on this matter were therefore also discussed. This topic had been added after the pilot interviews as one of the participants had suggested that job action should be included and came up naturally in most cases, as the strike was hotly debated in the media.

While I formulated the questions over a period of a few weeks, I sought input from nursing colleagues, such as my students, other teachers and members of my thesis support group, as well as feedback from my supervisor. I would ask everyone about their understanding of the questions, if they made sense to them, was the wording clear or should it be changed and whatever other feedback they volunteered. This helped me fine tune and ensure a shared understanding necessary for data 'reliability' and 'validity'. After I had formulated the semi-structured interview guide I did a pilot study with two nurses. It provided me, not only with a 'feel' for the nurses' worldviews, but also with further confirmation that the data I sought to obtain would be relevant to the phenomena of concern. There seemed to be enough flexibility in the questions for me to probe and for the participants to expand on the topics as we saw fit. The subsequent analysis and interpretation within the conceptual framework of Foucault's thought on power and subjectivity, I believe, brought new insights and points towards some novel strategies for change. As an ongoing validation I continue to share my 'findings' with other nurses and sometimes even with former participants. The feedback is that it 'rings true' to them.

May (1991) cautions that when research is done in the investigator's "own cultural milieu" (p.196), subtle factors may be missed through preconceived understandings and by use of specific language. I believe that I was 'close' but not 'that close'. Even though I am familiar with hospital nursing, I have not worked recently in the climate of restructuring. As my topic is the experience of nursing within the restructuring context, I believe it was possible for me to be open-minded without my own understandings interfering unduly in the construction of knowledge during the interviews. However, many of the experiences the participants related were similar to my own. Even though the context had changed, I encountered many flashbacks to events in my own nursing career. There were many 'unities' that emerged within the 'diversities', which I believe have enhanced my understanding and interpretations of many of the larger issues involved.

### **Ethical Considerations**

Ely et al (1991) state that in qualitative research ethical considerations are built into each phase of the project. Ethics is concerned with “three foci: for the integrity of the research itself, for the participants with whom one works and for some broader social implications...” (p.219). An underlying assumption of a ‘naturalistic inquiry’ (Lincoln & Guba, 1985, p.87) is that reality is “a series of mental constructions”. How then can the first ethical concern be met and the integrity of the research be ensured? Ely et al (1991) as well as Glesne and Peshkin (1992) suggest the best way is for researchers to try and become self aware in regards to their own biases. Ely et al (1991) talk about ‘interpretive communities’ in which many different points of view are accepted. They encourage us “to present the points of view of our participants, to see life through their eyes, as well as our own...” (p.220). This should lead us to encompass multiple interpretations, in which we probably never can be ‘really fair’ but we should make public our biases as much as possible. This is the reason why I stated my own involvement in nursing in the beginning chapter and later discussed my conceptual framework at length. My own biases also shine through in the statements of intent of my research, such as to ‘value nursing’, ‘elevate it to its rightful place’, ‘make it visible’ etc., which I try to lay out in the open. They were the driving forces behind the research.

The ethical concern for the participants is to protect their anonymity, but also to respect and preserve their ideas as much as possible. This latter concern was strived towards by clarifying with them issues that I did not comprehend at the time, and by sharing as much of my project and its purpose as I could, to make them aware and involved in the study. Before the start of the interviews all participants signed an informed consent form following a thorough explanation of the study verbally as well as written (see Appendix A: Covering letter and Consent form). I wanted to make my intention clear to minimize researcher domination as well as a potential power differential, which could disadvantage the interviewees. If the participants perceived me as employing ‘strategies of domination’ they might employ ‘strategies of resistance’ (Foucault, 1982), such as holding back on their views and not sharing openly their experiences and ideas, or even consciously misrepresenting them. I wanted to ensure that they would feel free to speak their minds and be comfortable during the interviews. I believe that

Foucault with his thoughts on ethics as the 'deliberate practice of self' (Foucault, 1988) provides insightful guidance. That in ethical practice power relations, always and unavoidably unequal, are to be played with a "minimum of domination" (p.18) should also apply to research. Once more this involves constant reflection of the researcher on his/her own practice.

My goal was to let the participants speak their own thoughts, with minimal impact of my own biases on what was said. I see the nurses as the main players in this project, as active agents, not as objects to be studied and evaluated. Therefore quotations that capture the participants' meanings were included liberally to lay out the processes of how I came to my interpretations. Reading the participants' own words also allows others to draw their own conclusions, which might be different from mine. However, in the end, the researcher is the 'instrument'. It is by his/her interpretation, his/her choice which quotations are termed as significant to be included, and which ones to be left out. The changes that arose in the researcher's thinking and feeling and the insights gained, are what will appear in the final work (Ely et al, 1991). This is why Streubert and Carpenter (1999, p.29) stress the importance of an 'audit trail' of the research -- inception and process -- to document the 'confirmability of findings'. "The intention is to illustrate as clearly as possible the thought processes that led to the conclusion".

Before giving 'informed' consent, the participants were made aware that taking part in the project is voluntary and that they may freely withdraw from it at any point. Any aspects of the research that have the potential to affect their well-being also needed to be explained (Glesne & Peshkin, 1992). Some of the information might portray an unfavourable picture of themselves, other employees or the employment situation. Hence I made it clear to them, from the start, that I was very conscious of my responsibility to carry out my role with utmost consideration for securing the privacy of the individuals involved. I assured the participants that no one at their place of employment, or elsewhere, would be told by me of their identities. Codes were used instead of names and all identifying characteristics have been kept out of the transcripts. The audiotapes are under lock and key and will be erased when no longer needed. I am exerting utmost care in carrying out my researcher role respecting and protecting the participants' rights to harm avoidance and privacy.

Lastly the ethical concern for broader social implications is about the research's ability to



bring about betterment for society. Ely et al (1991) talk about empowerment of participants. “How should human inquiry be directed at securing the good of human beings?” (p.231) is an important question researchers should ask themselves in this process, they argue. It is in everyday life, in the “swampy lowlands where profession and research and social commitment are often undistinguishable that qualitative researchers seek the roots that nourish our growth” (p.231). This is where the greatest human concerns lie. Street (1992) using a similar metaphor refers to the bedside as the ‘swampy lowlands of nursing’. This is why the bedside and its practitioners, considered to be at the low end of the disciplinary hierarchy, are the focus of my study. I believe effective change can best be brought about from the ‘inside at the local level’.

## **The Plan**

### **Site Selection**

In chapter one I elaborated on the reasons for choosing the hospital as the site for my research. My own familiarity, the hospital as the major site of employment, the hospital nurses as ‘exemplary’ regarding the public’s image of nursing, and the major effects of restructuring in this particular setting were all factors in making my decision.

Initially comparable units of patient care within two different hospitals were selected as sites for my investigation, both still in the process of ‘restructuring’ at the time. One of the settings I had originally chosen, like the majority of hospitals, does not officially support practice based on a theoretical nursing perspective. Naturally the nurses there (group 1) are free to utilize any nursing theory as guide to practice, if they wish. As employment condition, however, they are only required to hold a valid licence as proof of competency in nursing practice and to follow the policies and procedures of the hospital and the College of Nurses of Ontario. The second setting has a strong nursing leadership. In addition to the usual reorganization of practices, such as adding unregulated workers to the ‘skill mix’ and a flexible work force due to casualization, a reconceptualization of the delivery of nursing services occurred. Therefore simultaneously a philosophy of ‘patient-focused care’ based on Parse’s (1992/1981) theory of Human Becoming was introduced.

Staff at this hospital are encouraged to take a course in the theory which is taught by

nurse educators. Nurses with Master's degrees and knowledge of the theory, as professional practice leaders (PPLs), are providing continuous, on-site support for the staff nurses. As the theory is endorsed by the nursing leadership of the institution it also impacts on policies and procedures that are being developed and reviewed, as part of the restructuring process. With the nurses in this setting (group 2) I intended to explore if and how a nursing theory, taught and officially supported by nursing management, changes practice and views of nursing and added this topic to the interview guide (Appendix B). A comparison of this site with others can be supported from a Foucauldian perspective. How one conceptualizes oneself as practitioner and one's work, the 'discourse of truth' one adopts and follows, will determine how one practices.

As it turned out I had to recruit not just from two but from multiple hospital settings. I will discuss these developments under the heading of 'journey'.

### **Selection of Participants**

As explained before, I believed that all participants should be staff nurses and directly provide patient care. I also hoped to obtain samples representative of the different cultural/ethnic/ racial groups, age groups, educational levels and possibly gender that constitute the nursing population in this city, to represent their different voices fairly proportionally. Random sampling, which tries to ensure representativeness in the quantitative approach, can not be employed in qualitative research, as sample sizes are too small. Bogdan and Biklen (1998), as well as Morse (1991) and Hutchinson and Webb (1991), describe the 'purposeful inclusion of participants with certain knowledge' as a mandatory approach for qualitative research. 'Certain knowledge' refers to knowledge the researcher is after. Individuals possessing it are considered as 'experts' of the phenomenon of concern. In addition to the above mentioned differences between institutionally supported theory-based and non-theory-based practice, I hoped to learn about the nurses' thoughts, comparing the before and after restructuring. Hence initially I was mostly interested in nurses with at least a few years experience, who would be 'experts' in comparing the differences. Morse (1991, p.139) refers to "the qualitative principle of obtaining information from experts" which demands theoretical, purposeful selection of participants. Furthermore "to ensure validity, all cases must fit the explanatory model" (p.139) hence must be

included, even if they appear uncommon. As it turned out I started with 'volunteer samples' by soliciting, included 'nominated samples' by asking participants for referrals, and within these two strategies obtained 'purposeful or theoretical samples' by selecting the participants according to the phenomena of concern of the study. The specific strategies employed will be further elaborated in the next section of the 'journey'.

### **The Journey: Recruiting, Sampling and Locations**

While I was waiting for the ethics committee at my educational institution to approve my proposal, I conducted two pilot interviews to test the reliability of my questions. Both participants worked at one of the hospitals I had chosen. One of the nurses had formerly been my student. She recruited a second volunteer. Both participants felt very strongly about restructuring and its devastating impact on nurses. I asked my questions and carefully analyzed and evaluated the responses that they stimulated. Then I fine-tuned some of my probes. I also invited the participants to think of anything else that should be included. As a result I added a question on the participants' opinions about strikes.

As stated above, when I first started this project I intended to recruit my interviewees from comparable areas in only two hospitals. Once my proposal was reviewed and approved I approached one of the institutions I had selected, which used the patient-focused care approach, and officially requested permission to conduct my research. I obtained the support from the chief nursing officer, who I provided with a copy of my proposal. She enthusiastically wrote a letter of recommendation on my behalf to the institutional ethics review board where my proposal was being evaluated. At this point in time, the end of 1998, the issue of staff retention began to emerge. Increasingly there was talk about an impending shortage of nurses. After being laid off many nurses left the country or even the profession, and found work elsewhere (Fletcher, 2000; Picard, 2000). To hear what nurses had to say about what was going on in the healthcare system must have seemed like an useful starting point, in efforts to prevent a further depletion of nursing staff and a looming nursing shortage. In December 1998 I got permission from the hospital's ethics committee to proceed.

The next step was to recruit participants. With the help of one of the educators and a

manager I had approached -- both known to me previously -- two units were chosen as appropriate for the study. I then began to solicit voluntary participation through letters posted in the nurses' mail boxes (See Appendix A: covering letter). To add a personal touch I made short presentations during two team meetings on the units regarding the nature and purpose of my study. At the first meeting hardly anyone attended. It was held during working hours, on a busy afternoon, and most nurses were unable to get away. Their non-attendance was a good indicator of their workloads. I briefly mentioned my research to the few that were there and asked for volunteers to contact me. The whole month before the next meeting went by during which I did not get a single phone call.

Since there had been such poor attendance at the first meeting, the second one was held in the evening around change of the twelve hour shift. It was hoped that nurses could attend before going home or coming on duty. Also it was a less busy time of the day. A few of the nurses dropped in and out during the meeting, but most of the ones who attended stayed for the whole duration. There were approximately fifteen people, mostly nurses, some physiotherapists and social workers, the unit manager, two clinical nurse educators and myself. During the meeting the heavy workloads were discussed and ideas of how to work more effectively as a team were brought forward and tossed around. Most of the staff nurses who came seemed angry and very upset about workload issues and assignment changes that they felt interfered with proper care. The discussion occasionally became quite heated. It seemed good timing for me to make my pitch. When I spoke I made sure to convey my genuine concerns that had given birth to my project. Morse (1991) talks about being an 'insider' can give you easier access. I therefore tried to capitalize on my own nursing background. I talked of my previous work as a staff nurse and my strong interest in improving working conditions for a job I personally loved and valued -- a stance conveyed to all participants throughout the project.

On this occasion, as I was talking with the nurses, I got the impression that many would welcome an opportunity to speak to me. At the end several people came forward and agreed to be interviewed. They left me their phone numbers. Since I had previously not gotten any calls in response to leaving the letters with my own number, I decided to take theirs. If I was to phone them I had at least a chance to allay any possible fears they might have. I began to call a few days

later. Three nurses agreed to meet me at their convenience, but there were others who put me off, saying they were too busy at the time. In two cases I always got the nurses' answering machines and left my phone number without success. One of them even had sent previously a personal message with her friend who I interviewed, that she wanted to talk to me. My numerous failed attempts to reach her and the others left me puzzled. For about two months I tried in vain to get in contact with them. To this point I had done only three interviews in addition to the pilots and now I was stuck.

Finally I phoned up one of the nurses I had already interviewed and asked her if she knew what was going on. I learned from her that after the initial enthusiasm had worn off many of the volunteers had voiced second thoughts. Since I was going to recruit on only two floors of the hospital, they were afraid that they could easily be identified. As the topic was a sensitive one, they feared retributions, particularly in the climate of insecurity that the restructuring had created. It was rumoured at the time that more lay-offs were pending. The three participants that I had interviewed had come across as strong and secure in their abilities. The nurse who gave me this information stated she herself "did not really care" and felt she "had nothing to be afraid off". However most other nurses were fearful about losing their jobs. This was when it began to dawn on me how devastating the impact of restructuring really was for them.

At this point it became obvious that my initial intention of comparing similar units in two institutions would not work. Even if people would speak to me, they might hold back on information that possibly could endanger their employment. Hence the data I would obtain might not be very informative for my purpose and lack 'validity'. It also occurred to me that my strategy of obtaining official institutional permission, as well as working with the unit manager and nurse educator, was probably suspect. Even though their relationship with the staff seemed to be good, they were not 'one of them' and perhaps -- in their opinions -- could not be relied on entirely. Hence I was unable to gain the 'trust' of the participants, an essential element to obtain credible data. It became clear that I would not be able to carry out the project by sticking with the original design. Therefore I had no choice but to expand my pool of participants into other areas. Of course this situation jeopardized my original plan to compare practice on similar units in two hospitals, one with and one without a theoretical nursing perspective. If at all possible, I still

wanted to compare data of nurses who practiced from the patient-focused care approach with others who did not. I believe that nursing theory, as an important 'counter discourse', could lead to innovative nursing practice.

To better ensure that my participants could not be traced, I changed my recruiting strategy. I now worked through staff nurses rather than nurse managers and educators. At first I approached nurses I knew for referrals from other floors of the institution, using the 'nominated sampling' approach (Morse, 1991). I only ended up with two more participants however; in the end I had interviewed five nurses who practiced from the patient-focused care approach -- no others came forward. At this point I felt it no longer made sense to restrict myself to two hospitals. To get the ball rolling I asked for referrals in other institutions all over the city. Once again I started with a volunteer sample of experienced nurses, a few former students and their referrals. My reason was that they could compare the before and after of restructuring. In this group some participants had already obtained their baccalaureate degree, others were working on it. Using the 'theoretical sampling approach' my aim was to compare the viewpoints of several groups of nurses. I asked these participants to refer me to staff nurses who held diplomas from a community college or hospital school of nursing, as at present, nurses with this type of preparation represent the majority. To also include their different voices I particularly wanted to hear the thoughts of those who are not interested in further education. It would allow me to learn about potentially divergent view points of degree and non-degree nurses. I will further explain how I used the strategies of purposeful sampling in the discussion of demographics.

The circle began to increasingly widen. With so many hospitals in the Toronto area I could reassure the participants that there was no longer a danger that they could be identified. A second advantage was that I did not need institutional consent. Talking to the nurses outside of their working hours and environment saved me the lengthy process of going through yet another hospital ethical review. The only criteria I maintained were that the participant was a registered nurse and practiced somewhere in a hospital at the bedside. As a result of restructuring many only worked in part-time positions. All of these part-time nurses held second jobs in a different unit of the same hospital or even in another institution. These participants frequently added some interesting observations by comparing their work places.

After a slow start, the interviews progressed very quickly over the summer months. Eventually I had more participants than I needed and selectively turned some of them away. I believe that once the nurses heard I recruited from hospitals all over the city, they felt assured that their anonymity would be protected and came forward. They also seemed to speak up freely. In the end, I am convinced that my data are better and more comprehensive than my original plan would have allowed, had it worked at all. In early September, about eight months after my two pilots and about five months after I had started actively to recruit, I had interviewed twenty participants. No major new themes emerged at this point, even though the details of experiences and perspectives varied somewhat with all individuals. At this point I decided to stop.

Some of the interviews took place in coffee shops or restaurants, others in my home or that of the participants, whatever their preferences were to ensure their comfort. Most of the sessions lasted a bit over an hour, some were close to two hours long; one with a new graduate lasted only fifty minutes. I began with social conversation, then explained the study's purpose and other information, answered any questions they had and assured the interviewees about anonymity and confidentiality. Then, after they signed the consent form, the official interview began. All the interviews were audio-taped. Initially most participants watched the machine somewhat nervously. That is why I asked all the demographic questions first. However, after a few minutes neither of us seemed to notice it any more until it clicked and reminded me that the cassette needed to be turned over.

### **Demographics**

Nursing remains largely a female occupation. Of the twenty participants three were male. I had to turn away several other men since I wanted to stay more closely with the percentage of males in the occupation at large, which is about 4.6% (Davis & Bartfay, 2001). Yet I also wanted to be able to examine the data for potential gender differences. One of the male participants was about to enter a Master's degree, the other two are diploma graduates. As far as ethnicity and race are concerned, the nurses represented a variety of different backgrounds, a diversity that had emerged naturally in the course of recruiting, as these were not criteria I paid attention to. Several of the nurses are black Canadians, several others white Canadians with English, German or

French heritages. Some were born in European countries like the British Isles and Germany. Others came from East Asia and the Philippines; one was from Africa. The majority of them had trained in Canada, a few in England and one in India. Several participants however had moved around and lived -- some even had nursed -- in different countries and continents during their life times. The ethnic make-up of the participants largely reflects the diversity of the multi-cultural peoples and nurses in Toronto. Their ages range from early twenties to fifties.

All the participants are staff nurses in hospitals. The length of employment in nursing ranges from two new graduates of a few months, to three nurses with over 25 years' experience. The length of employment in the present institution where they work varies from just having started there to more than twenty years. Many had moved around within their institutions, which allowed them to change their work without losing seniority. Jobs held before the present one ranged from none for several participants who were recently out of school to community work and jobs in other hospitals. One participant did 'outpost nursing' for several years, meaning she worked in remote areas of Canada's north, where nurses are mostly the only healthcare workers on site. Another one had moved around overseas and the United States, also for several years. One had done missionary work in the far East recently. Then there were several nurses who had switched careers: three of them had been teachers before -- one of them still teaches health care aids in a community college part-time -- one had been a secretary, another a buyer, and one had done for many years various jobs, mainly construction work. This last participant also holds a trade union job outside of nursing and now works in nursing part-time.

The participants' educational levels are as follows. Fifteen of the twenty hold diplomas in nursing. Three of these diploma nurses are working on their baccalaureate degrees part-time. Five previously had completed baccalaureate degrees. Of those nurses two are presently enrolled in a Master's program. One of the baccalaureate prepared nurses also had earned a degree in psychology. Additionally five of the diploma nurses hold non-nursing baccalaureate degrees: one has a degree in commerce and a certificate to teach English as a second language; one participant's degree is in philosophy and English, two others' are in arts and one in education. Another one of the diploma nurses had completed two years in arts and science but had never finished. Almost all have additional specialty courses that led to certificates in nursing or are



working on one. These certificates are: community nursing, community health nursing in First Nations, Northern clinical program, health assessment (one advanced), critical care and emergency nursing, coronary care nursing, operating room nursing, urology nursing, gerontology nursing, advanced critical life support, orthopedic nursing, illness and life style management, foot care, reflexology and healing touch -- a long and varied list of credentials. Two participants are also British trained midwives. Outside interests include acting and poetry for one. Another nurse works part-time as a qualified esthetician. One finished several business courses. One (female) took motor cycle mechanics and also owns and rides a motor cycle.

From experience I know that many nurses are interested and involved, be it with their own nursing community or the larger community. In addition to their educational credentials the professional and community memberships of the interviewees are quite impressive. They participate in various occupational associations. Most are members of the Ontario Nurses Association (ONA), as the hospitals where they work are unionized. Nine belong to the professional body, the Registered Nurses Association of Ontario (RNAO). Five are members of the Canadian Nurses Association (CNA), another professional body that exists Canada wide. Two belong to the Healing Touch Association, an interest group in holistic, alternative health practices. Others are members of one each of the following interest groups: Urology Nurses Association, Forensic Nurses Association, Emergency Nurses Association, Peri-natal Interest Group, Canadian Holistic Nurses Association. Some also hold memberships in various non-nursing associations: One belongs to a trade union, one is a member of a Teacher's Association, and one is a leading member of a community group, active in helping people 'back home'.

What also began to emerge during the data collection was that there were many splits in nursing. As already mentioned, of the experienced nurses, several had obtained degrees from post-diploma programs. Most nurses who follow that route work for several or sometimes many years after obtaining their diplomas. They then go back to school for two years full time, or over a longer period part-time, to obtain their degrees. They have the advantage of work experience. The three oldest women in their late forties or early fifties admitted they had no intentions of getting their degrees. Two felt they wanted to retire soon, the third, a single parent, supported a daughter in university. All three felt it was not worth their while at this point in their career.

However their stances can not be generalized. Some of my own students are even older, one is over 60. It is often a personal goal to obtain their degree. All three of the older participants, nevertheless, had recently taken courses to 'upgrade'.

A decisive split seemed to exist between experienced nurses and those new to the profession. I considered the nurses relationships with each other an important point to explore. Therefore I decided to include several new graduates, all of them holding diplomas, even though they were unable to talk about the 'before' of restructuring. As the interviews progressed, almost all my experienced participants seemed to agree on one thing: the 'incompetence' of recently graduated nurses, particularly the newly graduated 'degree nurses' from basic university programs. It seemed that the latter were universally viewed as being on the lowest level of an unofficial hierarchy. Even the new diploma nurses felt they were better able to perform the required skills than their university educated colleagues. With the universal degree preparation now legislated to take effect in the near future, this seemed an important point to explore. Nurses graduating from the basic degree program spend as many hours as the diploma nurses in practice settings during school time. However, most of their clinical experiences take place in the community, whereas the diploma nurses' practica are primarily in hospital settings. With an emphasis on communication and a broad theoretical base in the university programs, including liberal arts, there is less focus on technical aspects of procedures and tasks, which are the main emphasis at the college level. Naturally the former are initially less proficient in task performance than their diploma colleagues. However, in general, their communication and problem solving skills are thought to be better. As the subject of perceived inferiority of degree nurses had come up again and again, I felt I needed to include their side of the story. My last two interviews were with newly graduate nurses from a baccalaureate program.

Remaining flexible during the process allowed me to follow a natural flow of data collection, beckoning exploration of issues that emerged along the way. This is how I ended up with a variety of view points from different representatives of the nursing population, thereby developing a "rich or dense description of the phenomenon" (Streubert & Carpenter, 1999, p.22). An ethno-racial diversity had emerged by itself. For other aspects like the male-female, old-new and degree-diploma nurse varieties, I had used 'purposeful sampling' by selection. One group of

nurses that was supposed to exist -- as some of the literature had stated and as I was assured by participants and other nurses -- were those who supposedly relied on their once upon a time diploma training and subsequent experience and were against any further education. I asked the people who helped me recruit and twice was assured that such nurses had been found. However subsequently neither one of these nurses discounted education during the interviews. With the exception of the three older participants close to retirement, all those who are not already in possession or working on their degrees maintained it could be a future possibility. Every single one valued education, as all the additional courses they took attested to, although their views varied about which types of courses were most useful. In this regard the newer graduates, particularly, kept going back to school to make themselves 'more marketable', to find either their first job, a more desirable job, or simply to gain more knowledge and to become a better nurse. The more experienced nurses did it mainly to upgrade themselves or to get into a different specialty of nursing.

These findings cast some doubt on widely held assumptions that nurses resist education, as portrayed in the literature by some of the nursing leaders, such as Moloney (1992), which was discussed in chapter two. Perhaps the types of nurses she described exist no longer or maybe they never did. Or perhaps they are not found in a big city as much as in smaller communities where access to education is difficult and perhaps thought to be less necessary. Or possibly they do not share the same thoughts and feelings with their colleagues as they do with an educated interviewer, as a concern for 'social (un)desirability' (Brink, 1991) according to their audience may be playing a role?

I believe that generally these nurses who volunteered for the study have different qualities from many of their colleagues. However, they have the expertise demanded by the study, which is to get new perspectives on restructuring and nursing practice. Morse (1991, p.132) states that rather than being representatives of the general group "good informants must be willing and able to critically examine the experience and their response to the situation...the second quality...is that he or she must be willing to share their experience with the interviewer". I believe these criteria were met by my participants. It is to be expected that such a sample consists of nurses who care about nursing and strive to be good in their work. There are probably others out there

just doing the minimum required, though looking back I can not think of encountering many individuals of the latter group. I believe that many nurses, partly out of self interest, are on the average well educated -- even more so now, as it gives them a competitive edge. Due to nursing's 'invisibility', particularly in the shadow of the much venerated physicians, their qualifications are not usually publicly highly acknowledged. Davies (1995) talks about this same phenomenon amongst British nurses. Education that does not provide for upward mobility at the bedside is not highly regarded by others outside of nursing. She found it is important to the nurses themselves, however, as they feel it enhances their knowledge and capabilities for their own satisfaction. This is congruent with my own experience. Most nurses seem to value education that is practical and enhances their abilities to practice.

### **Significance of the Research**

In today's climate of cut-backs to healthcare I believe it is important for all nurses to become aware, as much as possible, of how they themselves participate in the restructuring processes through the power relations at play. To bring about change they need therefore to learn about how their subjectivities are created historically and at the present time, by others and themselves, and how they themselves perceive and are perceived. From there we can begin to explore new possibilities for nursing's future. It is a process of finding novel ways of understanding and clarifying values of the discipline through reflection. By focusing on individual hospital bedside nurses, at a particular point in time, I was aware that many of the anticipated findings would be specific to these individuals and the historical context, representing their diversities within nursing.

However, I believe that also many commonalities were uncovered, affecting all nurses wherever they practice. As an occupation they are a group with a common history, common professional associations, regulatory bodies and common legislation. Therefore their experiences are influenced by many of the same forces. The differences in concerns of nurses practicing in a variety of settings are not absolute, but rather more quantitative and qualitative in nature according to the location of their employment. All nurses' work lives seem to be controlled from outside the occupation to an extent; however the work setting is a factor in the degree of control

imposed on their autonomy, with hospitals being the most traditional and hierarchical institutions. I also believe it to be extremely important for all nurses, including the ones in leadership positions, to become aware and concerned with the specific issues affecting the majority of their colleagues, who work at the bedside in hospitals. Only by dialoguing can we achieve understanding of each other, unite around common concerns, support each other effectively and shape a strong, cohesive nursing 'culture'.

The project provides an opportunity for the accounts of bedside hospital nurses to be heard and added to the discourse. Perhaps through awareness and solidarity a framework can be developed to allow for a more practical conceptualization of nursing issues -- more egalitarian in relationships between nurses and with other disciplines. I reason that, by raising awareness about the forces that shape occupational identities, we can find new ways of envisioning and striving for professionalism in a less oppressive and more egalitarian way. I believe there are implications for policy developments, political activism, and for education in nursing schools as well as practice settings, the main locations where occupational subjectivities are deliberately formed and maintained. It is hoped that the findings of this project therefore have meaning for all nurses practicing anywhere within the health care system. And perhaps there are larger insights to be gained about professionalism in general, particularly for 'female' occupations. This, however, is not my judgment to make, as an 'outsider' but should be decided by the members of these groups (Rolfe, 2000; Streubert & Carpenter, 1999).

### **Data Analysis**

"Data analysis involves organizing what you have seen, heard, and read so that you can make sense of what you have learned...to do so you must categorize, synthesize, search for patterns, and interpret the data you have collected" (Glesne & Peshkin, 1992, p.127). The process of data analysis began with the two pilot interviews, through which I 'tested' my interview questions and then evaluated and refined them for use with subsequent participants. This process of 'fine-tuning' continued right to the last interview. I always tried to transcribe the interviews as soon as possible. As there were often several days or sometimes weeks between them I kept up quite easily and seldom fell behind. I also integrated field notes I had written after the interview

in the appropriate parts of the transcripts, such as “participant seemed passionate when answering this question...sounds disillusioned on this topic...”. This strategy allowed me to remember as much context as possible. Listening to the recorded tapes also brought back the non-verbal language and nuances of intonation that, in addition to the spoken words, convey so much of the meaning. As I typed early themes emerged that I recorded at the end of the dialogue, including comments and a summary of my impressions. Progressively my questions became more focused towards the later interviews. For example when almost all earlier participants commented on the incompetence of new degree graduates I made sure to ask participants who had not mentioned it about their stance on this issue. For easier reading the transcripts were printed out.

After all the interviews were completed I used the interview questions as my early categories. At first I reread all the comments, one question at a time, pulling out significant sections and thoughts about them which were turned into ‘analytic files’ (Glesne & Peshkin, 1992) and again printed out. Besides the codes that were contained in the interview questions such as ‘ideal nurse’, ‘personal philosophy’, some of the other codes that emerged were ‘nursing is tough’, ‘nurses eat their young’, ‘nurses want ‘pats on the back’. Slowly the coded data seemed to arrange themselves into different layers. The most superficial layer was the experience of restructuring from the participants’ perspectives -- how they felt about it, their universal as well as individual complaints and some ideas about what could be done differently. Patterns began to emerge representing the trends of the process of restructuring and the shifts in reorganization of their work -- some were positive, but most were devastating.

For the second layer, I looked at data of how the participants, as active players, themselves participated in the process through their relationships with others in the system. Again patterns emerged that revealed some conscious as well as largely unconscious structuring of their roles vis a vis the other players: patients, other nurses, physicians and administrators / managers were the ones most significantly impacting on their work. The last layer dealt with their self styling practices. It revealed more clearly the ideal of nursing practice they envision, and what they see as socially desirable, for themselves as individuals as well as the collective of the discipline. Their thoughts further brought to the surface what interfered with / promoted these aspired practices. Along the way some findings were surprising and raised new questions for the

future of nursing.

### Summary

In this chapter I have discussed the reasoning I followed when choosing my methodology, in order to create an audit trail. I also showed flexibility during the process, partly due to developments beyond my control and partly because I was sensitive to the natural flow of the data that emerged. Therefore my recruiting followed, where possible, the theoretical sampling approach. Many splits emerged that allowed me to compare groups of nurses that shared common characteristics, such as gender, education or length of employment. I also was open to the commonalities amongst the diversities.

In the next chapters I am discussing the analysis of the data from the actual interviews themselves. I will start with what is obvious on the surface, the facts and ideas that were said, and go on to what was not said, yet implied or inferred. It is a process of slowly peeling the layers from the lived experiences and thoughts that my participants express, all the while relating and situating these data to the various discourses that tell us how to 'know' about and interpret the world. As Dr. Chambon (Feb. 16, 2000, personal communication) suggested, I see the data as images superimposed on current context and prior representations, such as the discourses that were structuring knowledge at the time in my own and the participants' experiences. These discourses live on. Their images gradually come into clearer focus as the layers surface, exposing snippets of what lies underneath. At the same time new possibilities for viewing and interpreting the picture differently appear, pointing to new ways of how the dominant view can be resisted, and how reality can be (re)constructed.

## **CHAPTER 5**

### **RESTRUCTURING FROM THE PERSPECTIVE OF THE BEDSIDE: THE BEAST THAT FEEDS ON ITSELF**

#### **Introduction**

In this chapter I begin my analysis of the interview data. I am reporting and interpreting what the nurses at the bedside have to say about their experiences of the restructuring process. Foucault (1982; 1980) suggests, for the investigation of power mechanisms, we should start at the local level where they are played out. As described in chapter three, restructuring emanates from, and is fuelled by managerial science. Its aim is primarily to increase efficiency. The emerging discourses are centred around the necessity of deficit reduction and introduction of market principles into healthcare. Nursing's goal, on the other hand, is the well-being of patients, therefore a dissonance between the goals is evident throughout the data. In keeping with the purpose of the project I will focus on the nurses' experiences as they tell them. The effects of restructuring on the work place and the roles of healthcare practitioners, from the participants' perspectives, represent the first layer to be examined. There are a few aspects of reorganization that brought about positive impacts. On the whole, however, restructuring processes are perceived as devastating, leading to stress, insecurity and disillusionment amongst the nurses. These effects then further reinforce the conditions that made them possible, like a beast that feeds on itself.

#### **Major Themes and Trends of Restructuring**

##### **Participants' perspectives**

I have to say it [restructuring] has been a frustrating experience, mainly because I am kind of sitting on the sidelines, seeing what is happening...and not really liking it. There has not been a lot of consultation with the bedside nurses, the nurses who are on the front lines. (Carol)

Bells are not answered, there are much more bells, I don't know if that is because nurses get burned out easily...but I have noticed that that is happening. While now, you may look after that patient today, tomorrow there is someone else. There is no...there is consistency but no responsibility for any particular patient. You are



just going to work and that is it! Total patient care for the eight hours. (Sarah)

In this section I will explore the current trends that affect nursing, patient care and eventually patients and their families. The nurses' main concerns over current issues in nursing are captured in the statements above. Carol indicates that many others were involved in the design of restructuring -- other disciplines, management, politicians, even the public to some extent -- but not the bedside nurses. Yet it is at the frontline where they work that the plans actually get transformed into actions. In spite of the fact that bedside nurses bear the brunt of the decisions about cuts and funding and are also the experts on the patient care they deliver, Carol states "they were sitting on the sidelines" during the planning process. She believes that the 'wrong people' were consulted, as these individuals are not necessarily knowledgeable about bedside care:

There has been [consultation] with a lot of people who are in the education system, people who are employing nurses and community members. But, I have not seen a lot -- nor did I read a lot in what I have seen of the task force report -- a lot of feedback from staff nurses who, I think, are taking the brunt of the restructuring...A few of the statements that have come out regarding that, I think, have been inaccurate and not been based on staff nurses, if they have been properly interviewed...I believe they did not interview the right people.

If nursing was represented during the restructuring, she believes it was through special groups, like the nursing union, with their own vested interests:

And the people they interviewed interpreted what they saw as the issues in a very inaccurate way. There are maybe a lot of reasons as to why these statements have come out... mostly based on securing an employment issue...other than a nursing issue. It was not based on how to improve nursing as it is, it was based on how to secure nursing jobs. I would think a lot of that came from ONA [Ontario Nurses Association, the nurses' union]. I think because they had a voice in there and they did not ask the staff nurses per se, I think that was probably one of their interpretations.

She implies that the negotiations took place to further some narrow goals of these various interest groups, whereas broader issues, such as quality of work and worklife, were kept off the agenda.

She feels left out and disregarded, even by her own leaders. Anna, working in a big city hospital, similarly asks in passionate desperation why everyone, even the public, were apathetic: "And why is it that nursing is ignored in such a leading institution and what is it that society allows them to get away with it? How and what do they know and what do they do with the knowledge that they know?"

As the second comment in the beginning of this section implies, staff burn-out and patient dissatisfaction can be correlated with the number of call bells that are ringing. It seems to be an universal symbolization of how busy the nurses are -- as similar metaphors emerge over and over again. Esther, describing times when staffing had been better, states: "It was observed that the patients' call bells were answered promptly...But, as I said, now everything has fallen by the wayside...". Corinne works in partnership with an RPN (registered practical nurse), which means she is responsible for all the highly skilled treatments on both their patients. She sounds extremely stressed: "...sometimes it is so busy... the bells are ringing, I have IV (intravenous) medications to hang up. ...because the call bells are ringing, you know, I have one head, two hands, I can not answer if the RPN is not there...either busy or not caring... depending on people's attitudes". To further give a flavour of the restructured atmosphere, Kathy talks about nurses being "stressed to the gills". In her setting "new nurses are leaving as quickly as they came". She states graphically that she can understand why: "...because they can only do so much efficiently, you just can't go to the bottom of your teeth, that kind of thing".

When asked about positive aspects of restructuring some changes are mentioned as having brought about improvements. Bruce sees the restructuring process as a potential opportunity to promote better allocation of nursing's expertise: "I think that there has been more of an internal reflection about nursing and what we do..." Specifically, he believes that there was a closer look at the RN and RPN roles in relation to the technical aspects of nursing's tasks on his unit. As technical skills are a large part of any hospital nurse's job, Bruce believes that downloading of some of these tasks is justified and could be freeing nurses for more important uses of their time, despite the opposition of many of his more traditionally minded colleagues:

One could say, if you are doing the exact job of an RPN and at almost 25% more cost... in this day and age cost seems to rule somewhat... historically, we always

looked at our practice and defined it as medical tasks. But a lot of RNs are having great difficulties with this. Each time a new task is given to an RPN some of my colleagues say: Well, what is there for us to do now? I can see our roles vanishing, they could be vanishing... yet... one of the challenges of the future is to get RNs to look at their roles in another way!...I think they are sensing that that needs to happen... I think it is being sabotaged a bit.

One of the effects of restructuring that is universally welcomed is an increased trend towards closer collaboration with the other disciplines at the bedside, commonly referred to as multi-or inter-disciplinary team. It consists of social workers, physio-therapists, occupational therapists, dieticians, pharmacists, physicians, sometimes chaplains and any other health workers that are special to some areas. Working more closely together is applauded as it helps the team members to understand each others' work much better, thereby facilitating improved cooperation and coordination of services. The participants feel that, when everyone is using the same techniques for assisting patients and the disciplines reinforce each other's teaching, the benefits to the patients are greater. It also seems to lead to greater respect for each other's contributions. Danielle's comment is typical: "Pharmacy, social work, they are much more on the floor... we see them much more frequently, you know who they are and you can access them a lot easier...things get done, we figure out what the problems are and work things out right away...like everybody is listening". Ronnie adds:

Having our own pharmacist, having our own social worker under the same health group, that I find is very good...before, when they had all their own departments everybody was working independently of the others. Now, we sit on committees together, it really helps, as far as the disciplines working together, it is really enhanced by that. We... learn about each others' roles. You work in partnership with the staff, it does not matter what level you are, everybody works in partnership.

These relationships will be examined more closely later.

In most places restructuring seems to be a centrally designed process that did not take into account the diversities of the settings. An exception is Esther's unit. She relates that the nurses on her floor were actually involved in the decision making. She feels that there was a collaborative attempt for improving care, as they all tried to work out how best to restructure in

their particular setting under the newly imposed conditions: "When we did restructuring on our floor some staff members were involved, I was involved. There were two nurses with the manager; we did get someone from the outside too. We felt that we should get feedback from all the staff members, not just nurses, because we have services different from other floors. So everybody should be involved with the restructuring". It is worth mentioning that, in this particular unit, the full and part-time staff had remained fairly stable. This fact may have facilitated their involvement, compared to other floors run mostly with transient labour.

Another recent development is the inclusion of nurses into committees and councils for decision making. In most hospital units these bodies deal with matters such as hiring, ethics, policies and procedures. The nurses who join in committee work see it as a good opportunity for their involvement in workplace issues, as Ronnie's comment shows:

In the past it was only the head nurse, the educator and the charge nurse who made the decisions, not everybody. Now all the staff nurses have joined a committee, so everybody has a say...and eventually through discussion, through minutes, through voting we come to a decision...Before we felt on the low end of the totem pole, whatever happened at the top, we did not know. Now we are involved.

However, there are some problems with nurses' attendance, due to their needed presence at the bedside, as Shelly explains:

You know they want you to join committees, they want you to work out things... like when we have a staff meeting,... and the head nurse is really good actually for throwing it back at you...like now she expects us to do everything... it is like well, how do we expect her to do everything? Like we present a list of whatever needs to be done and she will just say, okay, who wants to do that, who wants to do this? I don't think nurses would mind doing this or that... but, they will do it on hospital time, not on their own time.

And...see if they want you to come in for a meeting, well you are not paid for your time while you are there for the meeting.... why the heck should you come down? If people are commuting from distances, it is like: why should I take an hour to get down there and an hour to get back and attend a meeting for two? That is four hours of my time...And they can't even put out a coffee for you or whatever! Enough is enough! You don't expect me to be there and that is how a lot of nurses feel... like, why should I?

The meetings are held in regular day-time hours, to accommodate the majority of the healthcare team members. As workloads are heavy, the nurses who are on duty that day often find it impossible to get away for a period of time to attend a meeting, as usually no extra staff is provided. Other nurses, due to shift and weekend work, are off-duty at the time. If they come in for meetings they are not reimbursed. Ronnie too admits that therefore, “not all of them [nurses]... I don’t want to use the word ‘cooperate’, because some of them due to their family, with kids and babysitting, having to come during their off day, can not actually come”. Ronnie relates that in her department the nurses are trying to bypass some of those difficulties by designating certain people to go to meetings. These delegates then take notes and report back to the other members, either in person or by telephone, each of them being responsible to notify a number of staff. In an attempt on part of the nurses to include everyone in a more open and democratic process, staff are also encouraged to write their concerns in a communication book to be brought forward at the meetings.

Another problem reported is that of self perceptions. Shelly and others believe that many nurses feel they are not of equal status with the other members of the healthcare team and do not value their own contributions:

You know one of the girls I am working with now feels that way! She is on a committee, I think it is a quality assurance kind of thing. At the first meeting, it was 2 or 3 head nurses, couple of doctors. They went around the table introducing themselves, who I am and here is all my letters, and they got to her, and she is a diploma nurse, she is in her fifties and she is... and I am sure she literally hunkered down in her chair....well, I am just so and so and I am a nurse here... which is too bad in a way, because you should not be just a nurse... nurses have a lot of skills! They don’t even see it. I said, you have no idea what skills you use during the course of a day. And they are like, like what? Like they are totally oblivious, and see that is the problem, the whole mind set I mean... if that is what you think it is, no wonder!

Danielle comments on this subject: “I think for the moment, for most of us it is kind of intimidating ....A lot of times the leadership of these committees are not the staff nurses. They are either the social worker, the educator...I don’t know if it is people with degrees, if that is the sort of thing they are going by? Possibly...”.

Some of the long time nurses talk about their memories of what it was like to work in hospitals before restructuring. These participants mention that, on the whole, restructuring forced everyone on staff to take into consideration how they are spending health care dollars. Many recall the wasting of supplies and other expensive resources, as nobody then seemed to care. The more hospitals needed, the more they got, while the costs of health care spiralled. Jennifer even talks about “people all falling over each other”, due to overstaffing in her clinic. Now Jennifer feels “the pendulum has gone too far the other way”. Often unable to find time for a break, she since has learned about “the value of granola bars that you can eat on the run”. Cut-backs on all supplies, even basic necessities, are now described as severe. Several nurses talk about their frustrations with having to ‘borrow or steal’ from other units frequently, ‘just to be able to provide patients with a clean gown or linen’.

In some areas, nursing’s job descriptions have become more defined. Hilda, in her specialized unit, welcomes the lines between the domains of practice for the different health care disciplines that are beginning to emerge more distinctly. Comparing the present to the past she states: “It was even more stressful then than it is now, I think. That time it was very helter-skelter. Now, everything is super-structured. The guidelines are definitely much more clear”. Kelly too is in favour of specialization of nursing work, which she sees as going hand in hand with greater respect for nurses: “And I think if we are articulate enough, people at some point are going to have to listen...Like other professions we too choose specialties. It was a lack of respect before and we are demanding respect now! We are making it loud and clear that we are more than doctors’ hands”, referring to recent job actions by Canadian nurses. Anna, however, is more cautious in seeing specialization as the answer to problems. She feels that, at least in the acute care hospital settings, the much hailed and highly specialized nurse practitioner role has largely been assimilated into the existing power structures: “Our acute care nurse practitioners are basically physician assistants with all their knowledge...”. She leans towards branching more into prevention of illness, health promotion and emotional support that nurses provide, which is distinct from a medical focus and can be generalized to any area of nursing. Thereby new ways could be found to elevate the jobs of all nurses, she believes.

Despite some attempts to involve nurses more in collaborative teamwork, and although

there are local differences across institutions, there are two major trends that are perceived as responsible for the stress caused by restructuring. In the name of 'efficiency' casualization of the work force has occurred and workloads have become heavier. For the nurses the trend towards part-time employment offers neither job security nor benefits. Of my participants all of the more recently graduated nurses had been unable to find full-time positions. In response, several of them work as 'casuals' for two or three employers or for different units in one institution. This counter strategy, they state, helps to ensure adequate working hours. It also allows for greater flexibility in regards to when and where they want to work. However, they regret the lack of consistency and report that, as a result, many nurses now view their work as 'just a job'.

All the nurses I interviewed, no matter what their level of experience, feel that the heavy workloads interfere with their abilities to provide nursing care as they would like to. However, the effects seem to be most devastating for newly graduated nurses, the ones with the least seniority and the first ones to be laid-off. Shelly states: "Those are the ones I think we really need to hang on to, because they are our future". For many of the new nurses, like Irene, who graduated in 1995, restructuring meant not being able to find a job. Irene recalls how she sent her resume to every hospital in the city, but was told everywhere that she needed to gain experience before she could be considered. "And you just felt like it was a vicious circle...how do you get experience, if no one is going to hire you?" It also meant that some of her fellow graduates remained in lower status positions despite their newly acquired credentials of RN. Irene: "I could not find a job on graduation, none of us, none of my class mates did. The majority of the girls in my class in the part-time program were RPNs and they were working at the time. And the majority often remained RPNs, because they could not find a job". Recently Irene finally landed a part-time position on a medical floor. Like many others I speak to, she hardly ever takes proper breaks and perhaps "eats a sandwich on the desk". By working straight through her shift, mostly nights, she hopes to get out at a decent time. She is not paid for missing her official break or getting off late.

Corinne, a new graduate, relates another response to the cut-backs. Many of her classmates, all baccalaureate prepared, prefer to work in department stores rather than in hospitals. With their starting salaries in nursing barely more than what they are earning in the stores, and

considering all the stress and responsibilities that they would have to deal with, they believe that nursing is not 'worth their while'. The situation is aggravated by the fact that often the only job in nursing they could find during the last few years was through agencies. This means working all over the city in different institutions. Even when hired by hospitals today it is mostly part-time, working for more than one floor. If they are also 'new' nurses who lack experience they are doubly limited. Corinne's class mates refuse to nurse as they feel that under those circumstances it is just 'too hard to do'. In a recent newspaper article Picard (2000a, p.A5) confirms the exodus from the discipline that Corinne talks about. Picard claims that of the fewer than 8,000 graduating nurses in Canada, within one year "20 per cent of new nurses leave the profession altogether, joining thousands upon thousands of their older counterparts... there are almost as many qualified nurses in Canada working outside the profession as there are working as nurses".

Corinne herself reports that she is "just hanging in there right now". Her goal is to work in Public Health and she needs to get some hospital experience first, to gain expertise. She feels overwhelmed and scared to make mistakes and possibly lose her registration. She is also frustrated when she can not provide the care she would like to, due to her workload. At the end of the shift, she carries the burden of work home with her:

And sometimes I think, oh my God, I have to slow down, but I still need to keep going... people are crying from pain... I am thinking about the patients, because you want them to receive pain medications right away...it can be so overwhelming. I find that my license [is jeopardized]...when I sit down and think and even when I leave work, I am thinking...I hope that everything went well and I did not make any mistakes. That is the only thing I am afraid of. And again, 12 patients...to do the assessments, I don't think it is enough time. Sometimes I only get to see my patients for 10 minutes, actually sit and talk with them for 10 minutes...otherwise I am just in and out of the room, giving medications, emptying catheter bags.

Samantha, another new nurse, recalls that as a student she had been very disapproving of nurses who were "grouchy". Now she talks about the effects of the "overwhelming" workload and acuity level of her patients on herself and her co-workers, as well as ultimately the patients:

Now, I am working and I am so stressed out and getting irritable. And when a



patient asks me for a bedpan I am just like ahhh! I get frustrated and I don't have time for this..and I hate that feeling because...I don't feel it is right. But, at the same time, you have so much other stuff to do, it is hard to stay calm. So that is what I hate too and other nurses get very irritable as well. And then, when I need their guidance I think I don't want to bother them now, they are busy too, and then I don't ask... It is the patients that are suffering.

When things get too intolerable she hides in the bathroom just to get away for a few minutes and collect her thoughts. After the shift she often feels so exhausted that she does not want to see or talk to anybody, including her husband. As the stress in her work and her exhaustion lead her to withdraw from others, she feels the strain on her well-being, friendships, family relationships and even her marriage. Picard (2001a, p.A6) reports a very similar story told by a nurse in a Vancouver hospital.

Shelly, who has been in nursing for 20 years and therefore has a historical perspective, also describes some of the impacts that affect nurses in a very personal way. She recalls that three to four years before our interview, 1995/6 was the beginning; that is when

...we really felt the pinch...I think that was the point when they were really tightening up on the budget. Our workloads took a major leap. I did not really feel there was any support given to us at all. Some of my co-workers were let go quite dramatically and a couple of girls ended up on leaves for...psychiatric reasons. They just fell apart, it was terrible...a lot of negativity on the unit.

She talks about how the sudden disappearance of job security was devastating. No one seemed to care about what happened to nurses; they, as care givers, felt themselves discarded. Even those with many years of seniority got laid off. Nurses who had stayed for 17 years in one place were displaced from their positions by others who had 18 years seniority within the same institution. "It really just threw everybody for a loop. And you realize... you were just a number". In the end, she states, these events made everyone "take a second look at nursing as a whole".

One of the major recurrent themes is that nurses' knowledge and skills are underutilised. It is deplored by most of the nurses, whether new or experienced, however especially frustrating for Corinne, a recent degree graduate. The way her work is organized, she states, interferes with her job satisfaction and application of knowledge acquired in her university program:

No, I can't say that I am satisfied, no. I am very task oriented, it has become very task oriented....I am go, go, go. You know the nursing theory and what we learned in nursing -- talking about therapeutic communication, it is not there -- never used therapeutic communication much. I mean there is so much we learned at school, that I can't really use... doing a full assessment...there is so much I did, so much that we learned about, talking about social support and being there for the patient, oh my! I mean I am talking to my friends and my colleagues and we are saying, you know what we learned in school, nothing can be used here -- especially bedside nursing, because we have no time -- we went for four years to university to learn about theories that we can not use. Are we ever -- that is the question -- are we ever going to use what we have learned?

Corinne feels that what she learned can not be put into use where she presently works. Therefore her education is devalued and wasted.

Coming from a degree program, with my education... I did not think I would have to do everything, do a lot of this stuff, I did not expect that. (Like non-nursing stuff?) Yes, yes, yes, I could do more, with my education! That is what I feel, like... I need more challenge. I love more responsibility, but something that is more related to nursing... Some responsibilities are just ...not what I was prepared to do. Maybe a diploma nurse, which is fine, I don't mind doing it, but I could do more. Yes, I mean, a lot of what I learned in school, I have not used, because of no time. If I have an opportunity of time, I can utilize what I have learned and build on it. Knowledge, why not!.. and I want the opportunity and make more informed decisions as well. And use critical thinking skills too.

Jack, a participant who has been around for a while, calls the reorganization of work "the dumbing-down of nursing". He believes it is a strategy to facilitate its down-loading to unskilled personnel.

An universal complaint is the ever increasing number of non-nursing duties, particularly paperwork, that nurses have to deal with. Jack again: "Nurses are overworked, overloaded, and on top of this, inundated with what I call paper care, taking away from patient care...just an over abundance of paper care...job justification. Not job justification for the nurses, the RN level, but for somebody in the hierarchy, that really does not have much hands-on patient experiences". He explains that the production of paperwork acts as 'proof' for the bureaucratic efficiency of managerial positions. As discussed before, Campbell (1992) too perceives paper work as creating the textual reality, already 'categorized and sanitized', in which outcomes can easily be

demonstrated.

Even though tasks are given away to other healthcare workers, there are also more skills added to the nurses' repertoire. Bruce attributes this fact to ever expanding technology and to an increase in work formerly performed by physicians. For the much sicker hospitalized patients there are not only fewer nurses around now, but also fewer physicians. He thinks that deskilling is a strategy to increase efficiency and to lower costs, even at the level of medicine's work. These changes, he states, are demanding knowledge of nurses that is "more medically complex... not just in skills like IV (intravenous) skills, but also in medical assessment skills. With an acutely medically ill person you are doing a lot of medical work...". However, Bruce also talks about how, in regards to other tasks, one sees "a registered nurse pushing a stretcher... I think it is just a misuse of skills, talents and funds....it takes away from people at the bedside, where the nurse should be....". He further describes high absenteeism and less than efficient care as visible effects on nurses' health from all these pressures.:

...also shortages. We, on my unit, have 'worked short' [meaning with fewer than normally allotted staff] on more shifts in the last 6 months than we have in the 9 months previous [to them]. I don't think I have ever seen it like this. So, with a shortage of nurses there come more tasks and you are rushing... and... hospitals, the structure of hospitals, the delivery of care is still inefficient. Nurses still have to porter clients, nurses still have to go over and obtain materials.

Danielle seems to agree as she too deplors that the non-nursing duties take up much of the nurses' time. She describes that for six months they had no receptionist and the nurses had to fill in on top of their own responsibilities: "I am looking after the phones, after the phone lines, I am making appointments, I enter their appointments in the computer, oh yeah, I think a nurse does everything, change the garbage, you know..". However, what all the participants agree on is that the 'hands-on' patient care is too important to be fragmented. It should be done by nurses, not minimally trained workers, even if it means mixing highly complex skills requiring specialized training with simple ones and is especially emphasized by those who supervise lower-skilled workers who do the hands-on care.

Another trend mentioned is the increasing involvement of patients' families -- mainly

their women members -- in patient care. Thereby caring is shifted not only to lesser skilled workers but also to the unpaid and untrained public. This happens not only in homes but even hospitals, where now only the sickest patients are found. Sarah talks about how some families stay "just to help out. There is so much talk about the risk of being in the hospital". Worried about their loved ones, she believes they are often afraid to leave them alone on the understaffed units. Many nurses gladly engage the help of willing family members. However, Shelly points out that, when in hospital, patients are usually critically ill. Families therefore should not be expected "to cover our jobs. I do not agree with that at all. They are not trained". Engaging families' assistance may even endanger patients' safety, as she illustrates with the following example: Several relatives had stayed on with a critically ill patient in her workplace. The busy nurses were grateful for the 'help' as they felt they needed to watch the patient less closely. Later, when the patient experienced severe respiratory difficulties, the staff blamed the family for not recognizing the symptoms and alerting them sooner. Shelly argues that it should not have been expected of them, as they were not qualified to do this type of work: "...and yet they [health care workers] will say: 'you know the family did not realize that he was not breathing properly'. Why should they? That is not what they are there for...".

## **Discussion**

In the above section the participants speak about several trends that have emerged within the restructured system, indicating that there are many factors and strategies at play, producing heterogeneous and even contradictory outcomes, not all of them foreseeable. Some are welcomed, such as closer collaboration with the multi-disciplinary team, more highly skilled task performance to some extent, and participation in committees. Most other changes however, are perceived as detrimental to work life and morale of nurses. The major shifts seem to lead towards more 'routinized patient care' (Davies, 1995) through 'deskilling', which even affects physicians' work. Some of their previous tasks are now performed by nurses, which the nurses seem to welcome. Other nursing duties are given away to lower-skilled workers, which many perceive as threatening. However, lower-skilled tasks are also still loaded onto nurses' duties, as receptionist positions are not filled and nurses continue to porter, combined with the increased

workloads of their own. Despite the proclaimed rationalization of running the system more efficiently, there are currently many non-nursing tasks performed by nurses that probably could be done more cheaply by less trained employees. The participants refer particularly to answering phones, clerical work and pushing stretchers for transport. This seeming inefficiency is an indication that the people who make the decisions are ignorant of what goes on at the local level. It emanates from the invisibility of nurses' work and the widely held assumption that caring is a natural ability that any concerned person possesses. Davies (1995) maintains that nursing, as a female occupation, is lacking 'boundedness' and clear descriptions. It is therefore hard for others to recognize it as professional work. The accompanying 'casualization' of labour represents what Gustafson (2000) refers to as 'just in time nursing'. Perhaps efficiency was furthered in the short run with these strategies. As long as there were enough qualified nurses who needed to fill any available jobs to survive, positions of support workers were often eliminated and their work added to the nurses' duties (Glazer, 1988). However, the human factors, how this kind of treatment impacts on the nurses' morale and patient care, it seems was not considered.

As we have seen 'casualization' is particularly hard on new nurses for whom frequently city-wide staffing agencies are the only employers they can find. This arrangement is 'just in time nursing' (Gustafson, 2000) carried to the extreme. As it is too stressful for them some graduates prefer to stay in the sales jobs they had held as students. Others, who were Registered Practical Nurses (RPNs) before becoming RNs continue to work in the capacity of the former. The small differences in pay do not make up for the stress of working in isolation in unfamiliar settings with no experienced colleagues to guide them. If registered nurses work as RPNs skilled labour is had for lower pay and the institution, once again, wins. Perhaps many of the other young graduates have meanwhile moved on to other careers and joined half of the nursing workforce employed outside of nursing. However, lately the tables are beginning to turn. As there is now a nursing shortage these earlier cost-cutting measures are starting to backfire towards the employers. With more choices, the casualized nurses still in the system, pick and choose according to their preferences. The downside is that, as these nurses earn a living through a series of transient jobs, they feel less committed to any of them. More like mercenaries than professionals they now view nursing as 'just a job', a trend also confirmed by Fletcher (2000a).

The previously taken-for-granted 'selfless dedication' might be vanishing as disappointed nurses are learning to look out for themselves. Del Buono (1998) warns it is important for the quality of nursing to retain the right people, not just to fill positions for the short-term.

Another issue that always existed but gets exacerbated through casualization is what Davies (1995) calls the 'theory-practice gap', even as Nursing's scholars and professional bodies work toward theory-based professional nursing and more autonomous practice. Routinized nursing care, such as outlined in the care map discussed earlier, supposedly allows any nurse to step in easily to perform according to at least 'minimum standards'. This is the only way that casualization can work. It is ironic that, just as baccalaureate education is made an universal requirement for practice, the actual nursing work is getting increasingly deskilled, causing the theory-practice gap to widen even further. Corinne's passionate question if she will 'ever utilize what she has learned in university' illustrates this paradox.

It seems that on the one end nursing practice of some nurses, such as nurse practitioners and those working in specialized units, is becoming ever more complex and highly technical; on the other end many of the duties remain mired in the menial and trivial, another paradox. As specialization and the accompanying job descriptions worked well for medicine (Davies, 1995; Witz, 1992), many nurses too see it as an avenue to acquire the elevated status that goes along with it, such as the much hailed nurse practitioner role. However, as there are a limited number of specialized positions, this strategy will serve only an elite few. It therefore begs the question of what happens to the large majority of bedside nurses remaining in the poorly defined roles the nature of their work entails. Will they become support staff to the specialized nurses, as a further stratified hierarchy is created? As Anna observes, at least in regards to the acute care nurse practitioner, she believes a specialized 'handmaiden' was created, working in a new and complex role, yet again supportive to physicians (see also Mitchell, 1999). A different strategy is suggested by Davies (1995): redefine 'professionalism' by valuing 'sustained encounters' with patients, which could be accompanied by 'multi-tasking skills' in any setting, as thereby all nursing work would be revalued. The participants seem largely to agree with this approach, as they all feel that hands-on nursing care is too important to give away to lower-skilled workers.

Slowly some opportunities for nurses to have a say in the workplace are opening up, such

as through joining committees. 'Participatory government' and 'shared governance' are institutional discourses signalling a devolutionary approach to management. Yet, unlike the other team members nurses often feel neither welcomed nor supported. If they fail to attend they have no input. If they attend they likely become more actively involved in work-related decision making, instead of waiting for someone else to fix their problems; the drawback is that they feel they are taken advantage off, as mostly they have to attend on their own time. This arrangement seems therefore no more than a token gesture, as it contributes to nurses' ongoing marginalization within the disciplines -- a further sign of nursing work's devaluation. Doucette & Boyce (2000) report on a recent survey conducted by the College of Nurses of Ontario (CNO) as part of their Quality Assurance Program. They found that opportunities for the interdepartmental involvement of nurses receive the lowest scoring of all the indicators. To make things worse, as we have seen, nurses often feel uncomfortable amongst the other disciplines who are perceived as more educated. If they themselves do not recognize the value of their own knowledge and contributions, is it surprising that nursing remains 'invisible' to others?

The effect of the restructured system on patients and families, the very people that are supposed to benefit, is the most devastating. As we have seen, nurses who are overworked often engage the help of families inappropriately, relying on them to monitor their sick relatives during acute phases of illness. Not only is skilled nursing care devalued even further, government cuts seem thereby justified. As families 'seem' capable of looking after their own, their help becomes 'normalized'. The consequences for patients' and the families' own health can potentially be grave. Instead of engaging their help inappropriately, there is an urgent need for nurses to take a stand in order to protect their patients. Davies (1995) suggests that they elaborate and publicize the differences between unpaid caring work and professional caring. This does not mean that families can not help with care if they want to. But nurses need to be judicious in what they 'delegate' and what it is that they themselves, as a learned discipline, have to continue to provide. The roles they can play in counselling and supporting families need also to be further examined and theorized.

In the next section I will explore the impacts of the trends discussed here on work patterns, organization and control over the nursing discipline.

## Recent Shifts in Work Patterns and Control

### Participants' perspectives

... being part-time, the scheduling one day in a week, the continuation of care is not there! One day a week in one place, one day a week in another... They try to fill you in in places...you get these odd shifts, the continuation of care is broken. I think patients are longer in the hospital because of that. (Corinne)

And now you have got people who have minimal or no medical training, who have their MBAs, which is fine!..but it is a different approach...and they look at the health care system and they see that bottom line...they don't see how that bottom line came to be. And they don't see that there is certain ways you can go about changing that bottom line...not just dealing with business here...you are pretty well dealing with human beings all the time. (Carol)

In the above comments the effects of casualization on work patterns and patient care is described by Corinne, while Carol points out that behind this reorganization is a business approach. Jack, a strong advocate for team work, feels that with total patient care, "nurses work in isolation, fending for themselves". Hilda, talking about the past, recalls that even though workloads had always been heavy, nurses' work was facilitated through care delivery systems that relied more on coordinated approaches between them. Nurses then seemed to be the 'glue' that held hospitals together. She believes that their work was more under their own control compared to now, as then they worked as a team:

We were working hard like dogs, trying to fill in all the cracks....I think it was because nurses basically ran the entire hospital...in their own way, because there was not any of this restructuring. And if you were smart and a survivor, and you knew how to hang in there, you knew how to make the system work... and somehow we all managed to make the system work...we all pitched in. And there was a lot more of this team nursing before.

Whereas the more recently graduated nurses never even seem to have heard about 'team nursing', the other old-timers too deplore the loss of stable teams in the wake of increasing casualization, which they believe facilitated cooperation amongst nurses. Anna discusses that, as work was



reorganized in recent times, nurses' attitudes towards each other became less caring: "There is lack of support. When I started there was much more support, much more nurturing going on. It came from the nurses themselves, from the leaders, from the managers, who taught you this is okay, this is not; this is where you go to. Now you are out on your own".

Corinne below elaborates on the fragmentation of care arising from the current staffing patterns. She is also speculating as to the reasons why part-time nurses working in more than one place, like herself, are increasingly making up the majority of the work force:

Because they figured that way you would not call in sick as much...because as a full-time I would end up calling in sick all the time... because 12 patients mean...stress...and during stress your resistance is low, you get a cold. So restructuring, I wish they would give us less patients, so...we can give 100% of ourselves...and you see nurses who say, because that is my 5th day and I have had it!.. the morale just goes down... but then again, the nurses who work full-time they are exhausted, they are tired...and I am glad I am doing 8 hours (as opposed to 12). Sometimes I have to miss my breaks, just to make sure I am being on time to do everything.

Esther too talks about how quality of patient care is affected by the lack of continuity. On her medical unit the patients have chronic conditions and are mostly older. Remembering how work was organized in the past, she feels the nurses were a lot closer to their patients when there was 'primary care nursing'. This term refers to a type of care delivery in which one nurse is assigned to follow through on a patient's progress during the hospital stay. Knowing the patient s/he would plan his/her individualized care, ensuring consistency even when s/he is not on duty:

We did [before restructuring] have primary nursing and that was good, because there is continuity in care... The feedback from the patients was always positive, because you know the patient and the patient knows you. You have a mutual understanding of what you have to do for your patient and the patient knows, expects certain things from you. But with all that [going on now] there is no continuity at all how it is set up. And of course, because of that, we are going to have a lot of complaints, because patients are not satisfied.

In this unit, as was mentioned in the previous section, the nurses had been involved in restructuring decisions and staff had remained fairly stable. Esther relates that at this time some

of the nurses are taking the initiative to bring back the primary care system on their ward. They scheduled a staff meeting to talk over the possibilities with their unit manager.

Diane talks about some of the consequences of 'bumping' that had gone on during the lay-offs. Bumping is practiced in unionized organizations. When positions are eliminated a more 'senior' nurse can displace another with less seniority anywhere in the institution, as long as s/he 'qualifies' for the job. The displaced nurse then can either take the lay-off or also 'bump' someone who is less senior than him/herself. This process continues down the line till the least senior nurse has no choice but to leave, as there is no other place for him/her to 'bump into'. Diane had been working in a specialized unit at the time when extensive lay-offs occurred. Nurses who came on staff from other floors needed to learn the complex new skills and technology required for their new jobs. To save money it was decided for the training to be carried out not by an educator, but by the nurses who worked there, "...it just got dumped onto the staff nurses, of course".

Diane believes that "partly it was patronage, friends training friends that determined who got in", not their knowledge and skills. In several cases, even though the unit staff recognized that some of the new nurses lacked the required competencies, they felt under pressure to pass their trainees prematurely: "And then, some of the less conscientious staff persons were the ones who were too afraid to pipe up and say, what people were saying behind the coffee door...So, those people got pushed through...and are not coping...They can't even read a monitor strip! Extremely dangerous". This situation she states, was further aggravated by the newcomers' own feelings of insecurity and fears of job loss. They often failed to ask for needed help or to admit mistakes they had made, as it could be construed as lack of competence and cause for their dismissal. Diane explains: "I have seen people working alongside me that can't cope. They were too afraid to speak up to say, I can't do this and... they were being threatened that they lose their job...the mistakes that were being made were just getting too big...and nobody was listening...a lot of people were afraid of stepping on toes.." No longer wanting to be part of what went on she left this particular unit to work elsewhere.

Carol deplores the roles nurses have to play within the system that increasingly take them away from patient care. She feels that a 'business approach' was forced upon nursing, as

management was increasingly designing their work. She continues:

But we have somehow become more tolerant of the bottom line approaches in the business world, versus the health care system. And we are not so tolerant when it comes out of the health care industry, because ...we see more a human part of people... administration sees a person getting laid off not as a human being, but either as a commodity, or...as a fat, that needs to be cut, to balance the budget.

Danielle explains, nurses in management such as head nurses had at one point a lot of control, not only over patients but also over other nurses and staffing -- even the doctors bowed to them.

The problem, I think is, nursing comes from a background where people saw nurses as being very controlling. I certainly, when I first started, had some of those head nurses that were extremely controlling...and everything was the way they wanted it and even doctors were very obliging. You know they told you when to jump and you did it and that was it. So, I think that is sort of the problem where I think it has been an evolving thing, and then I think we swing over to where it is like sort of the opposite.

She too feels that nursing now lost control. Distant administrators without a nursing background, she thinks, are making more and more of the decisions that are affecting nurses and their work, as unit managers today have to be more concerned with the business aspect than the nursing aspect of their jobs. The hierarchical order still exists but has shifted from management with a background in nursing to a more generic administrative focus. As example she describes the security risks for patients and staff that are now resulting from an open visiting policy, about which the nurses were not consulted: "We have people come up 11 to 11:30 PM...you have all sorts of people roaming around the hospital, and we have to think about patient safety, staff safety... It is [a policy developed by] people that have long gone home and are not around at this time and they take offense with you, when you complain...". Karen, who works nights only, voices similar concerns. She recalls a situation when a patient's husband, himself confused, had been seemingly 'dumped' on the floor by his relatives. He kept wandering in and out of other patients' rooms in the middle of the night and "he is being a hindrance at this point", as having to check up on him was adding to the staff's workload.

Linda talks about how the long term care unit she works on was physically restructured. "We got all new furniture in there, in our unit I should say. And when you look at the furniture, there is no room what-so-ever, well... Nobody looked at the room sizes..." she laughs. She goes on about how they are presently "changing another whole unit into something nobody seems to understand". Expensive new equipment is put in, as for example a bathtub, which is useless due to the mobility impairments of their patient population, for whom wheelchair showers are more practical. She explains that in her setting unit managers hold meetings with all family members, to allow them input into some of the physical restructuring: "...you know it is kind of impractical and that is the whole issue. On this unit they have family meetings with the staff, to make decisions how to change... like the colours of the rooms... and what they want in their rooms... and... it does not matter what most of the nurses are saying, the family are the ones invited to come and look at the rooms...and so whatever they say, goes". She describes how some of the door ways are very narrow as furniture obstructs the path for stretchers and other needed equipment.

Anna works in a critical care unit. Even though she states that generally the nurses there have a higher status than regular floor nurses, they too feel excluded. The critical decisions regarding the courses of treatment for patients and what equipment to purchase, she states, continue to be made jointly by physicians and administrators, who are going over not only the nurses' heads, but also exert control over the patients and families:

Nurses are not consulted regarding restructuring. We teach physicians at the bedside, we help run cardiac arrests, we help determine factors in patient care, these are critically ill patients, yet in work place issues we are ignored. We are told that we don't have a knowledge base, that really, it does not matter what you say, I [hospital administrator? Doctor?] am the elite, the elite group... I will make the decisions, whether you like it or not, the door is always open...we will hire whoever we want...This paternalistic attitude in medicine is so dominant, and society at large are accepting it, I feel, they are not willing to stand up. Those who do stand up are ostracized, are called 'bad patients', 'bad families'.

Anna feels that a patriarchal regime of truth continues to operate in this setting, where administration's and medicine's knowledge matters, whereas nurses' or patients' knowledge is

discounted. She passionately declares that for the nurses and patients

there is no voice left. How can you change things when the elite male makes the rules for the elite male? There is a lot of cover-up going on. I do not believe that there is a new way of thinking. There has been no challenge to the system. Knowledge has been used as a weapon, people are not given credit for coming up with different ways of doing things. I think the way the system is, it is going to stay, it is going to get worse, it is not going to get better... I am not being cynical, just realistic.

Diane, who currently works in an emergency department, talks about some of the cut-backs imposed from the top in her setting. Recently she looked after a 16 year old teenager who lives on the street, and who had been experiencing abdominal pain. The patient herself stated that it probably was caused by hunger pains -- she had not eaten all day and felt starved -- but was also worried that it could be appendicitis or some other medical emergency. Tests showed severe dehydration as her only problem, due to insufficient intake of food and water. An intravenous line was started and she was rehydrated by pumping fluids into her. Afterwards she was discharged in the middle of the night. However, she remained hungry. Due to cut-backs no food was available and the patient had no money to buy something from a vending machine. Thus she was to be sent back -- to the street -- with the 'hunger pains' that had brought her in, still present. Thereby, Diane believes that the treatment she received failed to 'cure' her. When she compassionately shared some of her own food with her patient, she was criticized severely by some of her fellow nurses. They told her not to 'spoil the patient', as "she will come back for more".

Shelly, in the quotation below, describes her perceptions of the techniques used by administration in the restructuring process:

What they did to the health care....which was lay-offs, so you are losing all your young ones, because the old guys are all protected by their seniority and unions etc. and it is going to basically bring about more shortages and everything else. What is the point? It is almost like they take you down, degrade you, divide and conquer and then also, oh, by the way, we do have more money and yeah, we can start putting it back into the system and yeah, we can hire you all over again, and

then they wonder why there is no loyalty, or people are apathetic or cynical or just don't give care any more... you know, what do you expect, if you treat people like that: Humiliate you and then say, oh by the way, we think you are wonderful! Like even our own president and vice president were basically saying they could hire someone from the kitchen, who is a dish washer, to come up and do nursing skills! That was the ultimate insult! Which kind of makes you think, is that really what their opinion is of us? Is that their perception of what we do? It is just bedbaths, and pass bedpans? I mean that is archaic!

Attempts at degradation, she believes, were directed at turning nurses into obedient workers, through breaking them and destroying their self confidence. Derek, too, is convinced that the strategies of management are calculated to create fear and docility amongst nurses amidst the generalized climate of insecurity:

I thought I would have maybe a little bit more stability. One of the reasons I wanted to be a nurse was, that there would always be nurses, there would always be jobs. It is a pretty stable job, that is true. But when management, like the other year, tell us we are not valuable, and we may be laying off, or we may get rid of you, that affects you too. Even though I know in my mind that is not true! But it is a way of kneeling people down and controlling.

Jack fears the ultimate consequences not only for nurses but the population in general, as everyone gets used to the brave new world of diminishing services in the name of efficiency: "And it is a ...George Orwell, where... people are just going to tolerate more and more of a lower quality and lower standard, not just in life style, but in health care. And... as people are more and more conditioned to that, then their expectations will also be lowered and they won't remember how good it was...". Carol has similar fears. She too warns about possible consequences of tolerance towards the present approach:

If we get used to that kind of an attitude, we are asking for trouble... we are asking ...like to go to the private sector, for privatization. And that is more scary...it takes the onus for health care off the system and puts it back on the person...But it also brings you back to where the guy had to sell his farm to pay for grandma's stay in the hospital...but then business does not function in a humanistic kind of way! It is a system, it is a mandate.

## Discussion

Restructuring towards casualization of labour seems to have destabilized how nursing work is organized. Before restructuring a 'team' on a unit consisted of staff members who usually worked the same rotations. The team decided which tasks to split, and when to work together. The advantage was flexibility in how to arrange the work and even staffing according to the demands at the local level. A head nurse could call in extra workers if it got busy. The disadvantage was that work in some places became organized purely around tasks rather than patients, such as one nurse delivering all medications, another administering all the treatments. This arrangement is often referred to as 'functional nursing' and was a result of inappropriate and indiscriminate application of the concept, which led many nurse leaders to call for its abolishment. However, many places also had 'primary nursing', which meant that one nurse was assigned to follow through on a patient's progress during the hospital stay and was responsible for his/her individualized patient care. Yet this format still allowed the team to work together for selected chores, such as getting up patients who are physically impaired. Primary nursing, despite its congruency with nursing's values as it is based on getting to know the patient as a whole person, also fell by the wayside.

With the introduction of more casual and part-time workers it became necessary to move away from those forms of nursing which relied on stable staffing patterns for people to collaborate. It takes time to build good teams, which is also mentioned in a recent report on the status of nursing in Ontario (Picard, 2001b, p.A3). The members need to get to know each other to work together effectively. With casualization team nursing and primary nursing gave way to the so-called 'total patient-care', meaning that each nurse is responsible for the care of a number of patients. Despite the fact that workloads are centrally calculated, the official rationale provided for this mode of care delivery is to allow nurses to practice 'autonomously'. The number of patients per nurse vary, depending on how much of the nurse's 'time' will be allocated for the physical care (Gustafson, 2000). If the nurse works alone for a day shift it could mean one patient in an intensive care setting to six to eight on a 'regular' medical or surgical floor. During the other shifts the workload is much higher, especially on nights. Autonomy seems to be narrowly interpreted in this context as meaning that one nurse is responsible and accountable for all of

his/her own patients' care for the shift: 'total patient care for eight or twelve hours'. This form of care delivery differs from before when nurses approached the work as a team, with usually a more senior nurse as the 'team leader' who could be consulted by other staff when they were unsure about something. Now the 'care map' is the guide to be followed.

In some hospitals there is no more common report for all nurses about all patients at the beginning of the shift. This leads to further isolation, as nurses receive information only about their own patients. A longstanding practice, report is given to the whole team, either by a nurse from the previous shift in person, or through a taped account. This is the time when nurses find out about all patients on the unit, their illnesses, scheduled tests, previous events, their emotional status, families, anything that is relevant to their care. It is also a time to communicate with the other team members, to perhaps coordinate working together on some tasks that require team work, or simply to maintain social rapport. As it takes usually about thirty to forty minutes during which the team members sit and listen, this time was seen as 'unproductive' by some hospital managers. Therefore a short one-to-one exchange between the nurse of the previous shift and the nurse of the oncoming shift only concerning their own patients was put in its place. Yet, what goes on with other patients on the unit is no longer common knowledge. As a result, many nurses fear that they might do or say something wrong and therefore refrain from attending to someone else's patients; others are simply burned out and no longer care. They see nursing now as 'just a job' and, focusing on their own tasks, ignore what goes on around them. The format makes it difficult to coordinate helping each other and is particularly hard on junior nurses. As discussed in the previous section, they are the ones most likely to be employed casually, often by central city-wide staffing agencies. Therefore they are unfamiliar not only with the patients themselves, but frequently also with the lay-out, charting and all 'routines' on the floor. In addition, despite the attempts at routinization, due to the complexity of healthcare, recent graduates need various degrees of guidance in previously unencountered situations for years to come. Unable to bear the resulting stress many leave nursing altogether; some upon graduation never even get started.

In some workplaces the term 'team nursing' was assigned a new meaning. It now partners an RN with less qualified staff members, either RPNs, licensed / unlicensed nurse's aids or



unregulated workers over the duration of the shift, an arrangement that in some places is also referred to as 'modular nursing'. The role of the RN in this case is to provide highly skilled treatments to a number of patients, as well as coordinating and being responsible for all the care provided by the 'team'. Her/his role thereby becomes mostly one of 'managing' other workers who do the hands-on nursing. Even on a day shift the patients in this arrangement can number up to ten or twelve. The nurse dashes in and out of patients' rooms to perform the highly skilled tasks on the run. Considering the heavy workloads, coping with the assignment for that day is made possible only through following the routine protocols. There is no time for getting to know patients to provide more individualized care. As a large number of employees in a 'pool' staff the units, the next day the 'team' might be made up of different individuals or assignments might be changed.

Casualization seems to have several advantages from an administrative perspective. In addition to being less tired and more dependent on taking the work when it is offered, as Corinne speculates, the hospital does not have to provide part-time nurses with health benefits, hence they have no paid sick-time. Even when ill they often will not stay at home because they simply can not afford it. Statistics show that nurses who had paid sick time lost "a whopping 150 per cent more working time than the Canadian average for all full-time employees" (Fletcher, 2000a, p.20). This translates to approximately 15 days per year in 1997 and these numbers only speak for the ones who took it, as many others probably came to work sick.

Lack of job security and threats of job loss created an atmosphere of fear, imposing dangerous silences and inciting deviant collusion amongst the staff. An example is Diane's story when, in a specialized unit, new staff were trained by nurses who themselves were not necessarily qualified to teach others. Even though the newcomers were ill-prepared, they were prematurely thrust into working independently, as all involved, afraid for their own jobs, remained silent about the resulting inadequacies in care delivery. It is a further indication of how nursing, even in highly specialized areas, continues to be perceived as a 'natural ability' or, at the least, easily acquired in an apprenticeship mode by the people who make decisions. Practices resulting from these longstanding discourses perpetuate existing power structures.

Other examples show how someone far removed from the scene imposed changes --

perhaps well-meaning -- without considering the consequences at the bedside. Nurses are not asked or involved as policies are formulated, such as the indiscriminate open visiting hours. In other cases families are helping to choose room colours and furniture arrangement, whereas nurses who have to work there are not consulted. It further begs the question if the families' input is solicited to detract attention from the other detrimental aspects of restructuring, by allowing them a say in some of the more trivial issues. At the same time, if things go wrong, the blame can be put on families, thereby absolving those who planned the changes.

The example of the hungry 'street kid' in emergency shows how no money is spared for 'high tech' treatments like intravenous fluids, yet the much cheaper basic necessities, such as food, are unobtainable in the restructured system. Medical problems like dehydration are 'fixed' with intravenous therapy, while the underlying causes, such as lack of a meal, remain ignored. How could the individuals in administrative positions far removed from the bedside, who engineered restructuring, even begin to understand the intricate complexities of healthcare encounters at the point of delivery? When Diane was chided by her colleagues for sharing her own food, it shows how some nurses continue to comply with the system rather than standing up for their patients' well-being, despite officially claiming to be patient advocates. They forget that their primary responsibility, as 'professionals', lies with patients. By abiding to and even callously reinforcing the new rules, they help putting them firmly into place instead of advocating for change. It is an example of how power works through 'agonisms of strategies', 'colonizing' the docile bodies of the nurses whose subjectivities have been reshaped to serve the reorganization of the system. How through their own self perceptions and relationships with others they participate in the processes of power will be examined more closely in the next chapters.

Nobody seems to dispute that some restructuring was necessary. The problem, as the participants see it, lies in how it was done. Some of the strategies used were perceived as degrading by nurses, particularly when they further seemed to demean the value of their work. Restructuring produced instability and shake-ups. Once the pebble hit the water, the ripple effects were felt everywhere. It seems there was a whole slew of colluding circumstances, an 'ensemble of actions', by the various players involved that ensured that the new structures were complied

with, regardless of their consequences. In this next section I will report on the nurses' ideas on how restructuring should be carried out.

### **Participants' Ideas on Restructuring**

#### **Participants' perspectives**

There is money somewhere, because there always seems to be money for elsewhere, or for research or anything else. I mean I know nursing takes the biggest chunk out of the budget. And so it should! But they always throw that back at us, like well, you know, nursing is the largest portion of the budget. Well, you know what? Nursing is the budget! No kidding! It is like who the heck do you think is taking care of all these people? (Shelly)

I would start from the low people. I would never go to management first. Restructuring should have started with the nurses. They are the ones providing the hands-on care and they should have...maybe with some guidance from the management, like have a say, what do you want first, what do you want to see happening?.. And try to get their approval as much as possible. Then every one would feel a little more satisfied. I am not saying whatever you say will be taken in, but, at least if most part is taken in, you feel like you have been involved.  
(Linda)

As we have seen so far throughout this chapter the participants are unanimous in their convictions that bedside nurses should be more involved in the restructuring process; they want to have input on where and how cut-backs are implemented. Shelly's comment above suggests that nurses are the heart of the system; reducing their numbers comes at a high cost. She believes that most of the problems of restructuring stem from poor planning by people from the bureaucratic sector, who are unfamiliar with nursing's work, as is also suggested by Linda above. The impact of their decisions affects not only the nurses' work but also the quality of care they deliver.

Shelly likes the idea of moving health care out of hospitals and back into the community: "It was the whole idea of moving out of acute care and into the community... well, they cut all the acute care but they never put the community services into place before the shifting...and people

are falling through the gaps...so you have all that, the coordination and the bureaucrats and it is like, it is not their world...". Carol seems to agree. She believes that, with adequate support from properly trained staff, quality of life should be improved by keeping people in their own homes as, "with the long term focus of healthcare restructuring going to the community, I think there are a lot of benefits to that. People always have done better in their own setting". She welcomes the resulting heightened awareness on the reality of health and illness issues, which are part of life. Taking illness out of the home in the last few generations, she feels, has created distorted ideas about illness and death in people's minds. They tend to think that "you go to the hospital either to die or you are cured. And people don't see the different levels of healing or the different levels of dying...they have chosen to push that out of their lives and hide it away in hospitals. So, bringing it back into the community, I think, will raise some awareness...". Carol too sees the main problem lying not with the goals but with the implementation of the changes:

Ah, they jumped the gun from point A to point D and missed steps B and C in between. The community is not ready...either funding wise or level of people able to deal with some of the acute things they will be dealing with in the community. There is not enough nurses out there trained to do that...there needs to be a lot more education of the public...the families are left caring for them [patients], how it ages ago used to be. But you don't have these extended families any more that you can depend on.

Sarah states: "I think there are lots of ways we could sit down and brainstorm and see... not just impose things from above...". Derek too believes that "nursing [should] be more involved in running of the hospitals, versus a 'number man' or others who are non-nursing making the policies and procedures. Why does it have to be a doctor running the hospital?" Linda, as expressed in her comment at the beginning of this section, believes restructuring should start with suggestions from below at the bedside, as due to first hand knowledge, the nurses know best. She herself had helped develop bowel and bladder training for long-term geriatric patients on her unit. She states that initially it is a labour intensive process on part of the nurses but, at the same time, this measure promotes the patients' dignity and therefore their well-being and decreases the use of expensive supplies and laundry. Yet now, with restructuring priorities, this --

in the long run -- cost-saving, quality of life enhancing project had been put on hold, as funding for it was withdrawn.

Asked for suggestions on how restructuring should be carried out all of the nurses interviewed feel that the work load is the number one problem and should be decreased. This could be achieved, at least partly, by taking away their non-nursing duties. Jack goes as far as to suggest that the nursing shortage could be dealt with by giving away non-nursing tasks, thereby making workloads more manageable for nurses and better utilizing their knowledge:

We probably can do a lot more in nursing, with the staff that we have, without adding more staff, without handicapping them, tying their hands behind their backs, with triplication of all the various documentations that they have to do in their everyday practice...there is just no time to do basic patient care, whether it is a backrub, time to do treatments properly, or even listen to patients, find out what other current problems are happening.

Some participants who are part-time nurses think that getting at least more hours on one floor, if not full-time status, would greatly increase the quality of patient-care by providing greater consistency and continuity. They believe that the improved, more personalized care would actually shorten the patients' stay and reduce readmissions. Irene would like to see more flexibility with scheduling: "... and we need more ways to allow better scheduling, such as 'time sharing', to prevent burnout which starts to show in decreased quality of patient care...". Time sharing refers to one full-time job held by two nurses, who amongst themselves work out their schedules, each effectively holding a half-time position. Another popular format, self scheduling, through which the nurses have input into arranging their work times, will be discussed in the next chapter. Going back to primary care, with one nurse accountable for several patients in order to promote consistency, is specifically mentioned by nurses who have worked with this type of care. Derek, who had done "lots of agency work in the past", questions the widespread trend of hospitals using city-wide float pools. In addition to decreased quality care due to unfamiliarity with the setting, it seems to him also a fiscally imprudent practice: "How can you save money by adding the middle man? So, as a nurse I go to an agency, this agency sells me to a hospital. How are you saving money by paying someone in the middle?" Derek's suggestion in its place is to

“hire staff, educate them, treat them well...”, it would save money and improve overall the quality of work life and patient care, a suggestion also brought forward by Fletcher (2000a).

Other warnings the participants sound are about the deemphasizing and devaluing of practical experience. They believe there are not enough opportunities for bedside care for students during nursing school and that the orientation time for new staff is insufficient. Carol talks about restructuring educational experiences to prepare nurses more adequately for the job. She believes that it was through her own diversified practice that she acquired the most valuable knowledge. Like several of the others, she thinks it impossible to learn much of practical nursing knowledge in the class room. Particularly she maintains:

Problem solving and creative thinking are best learned in actual situations... You can study community health principles all you want, you can study transcultural nursing perspectives all you want... those are basic nursing knowledge things, that you need to work in any city, any part of the country....when I moved from the small town where I had trained to an outpost setting, when I was working with First Nations, that big cultural thing I had to learn all over!... and I learned it without having a degree... If you are going to have degree trained nurses as the entry level to practice, you have to give them more bedside clinical hours!

Despite the proclaimed emphasis on the value of education Irene, who works part-time to take courses towards her degree, talks about her difficulties in this regard, with similar concerns raised by several others:

I have the feeling that the hospital wants you to do things. But they don't want to know if you are stressed out. There should be more training for the new nurses that come out [of school], not just throw them on the floor like that. I know some hospitals do have good training, not ours. They don't even give me time off to go to school... They are very cocky telling you how they are education centred, and they want their nurses to upgrade... yeah, it's all talk! They want the best qualified nurses they can get, but they are not prepared to give them the time to do it.

Bruce suggests to reconsider the nursing role and perhaps give up more tasks on stable patients to RPNs and other co-workers, freeing the nurses for more complex procedures and assessments and particularly counselling. The nurses' input could help ensure that the 'right' tasks are given away. Derek proposes the allocation of funds be less directed towards buildings

and more towards human resources, particularly at the bedside: “No building has ever saved a life...There are hospitals in London that have been open for hundreds of years and they are still open and they are still saving lives everyday...”, he argues.

Jack also discusses the issues of funding allocation and waste: “I find it lamentable that they are closing down hospitals (names several). Those institutions could be better saved and utilized for long-term care facilities...instead of giving hard earned dollars out of tax payers’ pocket to private industry, to rebuild those buildings, when they are already built”. Jack muses about how “they [governments] want to blame nurses... and blame the small guy for a lack of fiscal responsibility, when it is really management, the corporate level and government level...ahhh...and their errors!” Shelly summarizes several issues, such as devaluation of nurses’ work, and makes some suggestions for reorganizing funding priorities and staffing:

I think [better] staffing is a biggie. Nurses need to feel that what they are doing is worthwhile. There just does not seem to be any funding for nurses.....no money, and if we do have money it is only for a list of things...Research is first and foremost, patient care is not! But I hear the doctors complaining too now that money is not going towards patient care but it will go to research. You can get all the money you want for research.

Anna offers her own interpretation on restructuring’s purpose: “The intent of restructuring was never to have checks and balances in the system, it was only to further oppress”.

## **Discussion**

Overall the nurses seem to agree that restructuring of the system is necessary. They find many of its stated goals even desirable at first glance. Yet HOW restructuring was implemented they feel has led to disastrous outcomes. They see it as imposed on them and the public by others ‘from above’, mostly without their input, and with no consideration for the human beings affected by this process, they themselves and their patients. One of the reasons restructuring sounded attractive to many, at least at first glance, seems to be the professed goal of moving caring back into the community. However, they state that the promised funding shift from acute care to chronic care failed to be implemented. There were not enough nurses working in the

community to look after the sick and the responsibility for their care fell therefore on their untrained family members. Even with families, meaning mostly their women members, willing to look after patients at home, thereby providing unpaid services and subsidizing the healthcare system, today's highly technical interventions are not as easy to implement as the basic care measures in the past. Someone needs to train the family care givers first.

Cutbacks have also affected the training of new nurses within the highly sophisticated technical environment of hospital care. Most orientation programs for new staff were shortened in content and time as a cost-cutting measure, as they were viewed as non-essential 'frills'. We have seen the dangerous ramifications of this practice in Diane's example, when the staff nurses in a specialty department were expected to train their colleagues to save the educator position. Even in nursing schools clinical hours now are spent largely in non-acute settings in the community. The advantage is that this arrangement exposes students to many other areas which perhaps are more conducive to autonomous nursing practice. However, it prepares them poorly for acute hospital care, where still the majority of nurses are working, at least for a while. It is of course not possible for nursing schools to graduate nurses who are able to function in all areas. Yet they need to be adequately prepared before taking on the responsibilities for their patients' well-being and even lives. They also need guidance in the first few years, the 'staff mix' needs to include some senior experienced nurses. The question is, should it be the mandate of the schools or the hiring institution to train them for areas they are going to work in? As long as nursing is viewed as a 'natural ability' or a 'string of tasks', easily accomplished by following a protocol, and nurses deliver 'just in time' care the training question will be swept under the carpet.

All participants would welcome increasing support staff to take over many of their menial non-nursing tasks, particularly paper work and answering phones, which would leave them free to engage their nursing skills more appropriately. It might even solve some problems of the current nursing shortage. Bruce's suggestion to 'download' responsibilities for more stable patients seems practical, as long as the nurses are involved in determining who counts as 'stable' and which tasks can be performed by others safely. Yet the challenge is to prevent the further 'fragmentation' of patient care. With the focus on the 'visible' technical tasks the less easily demonstrable 'counselling' aspects may still take a backseat. Interestingly similar suggestions are



echoed in a recent report on recruitment and retention presented to the government by the professional bodies for Registered Nurses and Registered Nursing Assistants. This report also asks for input of nurses, from the bedside to government ministries, on all levels of public policy, its development, implementation and evaluation (RNAO & RPNAO, 2000). Similar recommendations are made by Carey and Campbell (1994), Cooney (1994), Cronin and Becherer (1999), Del Buono (1993) and McGirr and Bakker (2000). It is encouraging to see that bedside nurses, left out of the official processes for so long, are specifically included.

As nursing comprises the highest budget in health care it is often blamed for all deficits, as Shelly suggests. The universal funding shift from human resources towards intensified medical services and testing, such as Huston (1996) and Prescott (1993) report, was discussed earlier in the section on managed care. It also seems that while lay-offs are happening to decrease expenses, in other ways funds are wasted, such as construction of new buildings, while old ones stay empty, and use of expensive agencies instead of regular employees. Restructuring, it seems, did not result in any actual savings but manifests the undervaluing of human services in society, including nursing.

### Summary

In this first level of analysis I try to capture the perceptions nurses hold about their redesigned roles in the context of restructuring. 'Sitting on the sidelines' and 'lack of voice' are major themes that emerge here and continue on through the layers of data. Nurses feel that restructuring was imposed on them 'from above' by people who lack understanding of bedside care. There is a general consensus that responsibility for organization of nurses' work has shifted from within nursing towards management. Fears are voiced that there is a 'tightening of control' from a centralized position over their work performance and that decreasing quality of care is systematically becoming 'normalized'. The participants recognize that the bottom-line is what counts as the mechanisms of the 'market' are increasingly imposed on the system, while ringing call bells remain unanswered, signifying lack of quality care and staff dissatisfaction with their work. To 'streamline' healthcare, the major strategies used until now were: reducing the number of healthcare workers and casualization, deskilling of jobs to be performed by other workers for

less pay, and closing of beds and hospitals. Nursing services, in particular, are labelled 'high budget items' that are dispensed with when cost-cutting is the priority. These measures result in higher workloads for the nurses remaining in the system and earlier discharges for patients. At the same time nurses' work got publicly derided by some administrators. After the interviews were conducted, I reviewed the literature on 'managed care', as I looked for an explanatory framework for the data on reorganization of care. The participants' accounts pointed toward managerial science as underlying the restructuring of institutional practice. Therefore this discourse 'emerged' while I was trying to make sense of the data.

In keeping with the neo-liberal agenda, there is an ongoing shift of responsibility for the well-being of the populations from the state and health disciplines towards the individuals themselves (Peterson & Lupton, 1996). The latter are now expected to look after themselves in the community much sooner than before, mostly with the unpaid and often unskilled help of their families and friends, as the promised funding shift to community care has not happened. Even in hospitals the help of families becomes increasingly a necessity, despite their lack of qualifications to recognize and manage illness manifestations, potentially leading to dangerous situations. It is questionable if even the promised fiscal savings materialized. For one the widespread use of agencies adds to the expenses. Secondly it is hard to determine to what extent prolonged illnesses and readmissions, resulting from a lack of adequate nursing care and premature discharges, are actually increasing healthcare costs. Add to this the cost of mergers and name changes for organizations, buildings that stay vacant when hospitals close, the trends towards increased reliance on testing and expensive technology and it becomes hard to imagine how overall savings could have resulted.

Due to the changes the percentage of very sick patients in hospitals, at any given time, is much higher than ever before. Medical knowledge continues as the dominant discourse in the delivery of healthcare, pushing for more expensive equipments for tests and treatments; nursing knowledge and nurses' contributions, on the other hand, remain poorly understood, even by nurses themselves, and therefore underutilized. Caring work is increasingly broken down into a series of tasks, which are performed by a casual, flexible 'skill mix' of nurses and less skilled / unskilled workers. In this arrangement stable 'teams' have all but disappeared. Previous 'team work' of a

group of nurses, often combined with primary care, has given way to 'total patient care', meaning a nurse is responsible and accountable to provide all the necessary care, for the duration of a shift. The results are fragmentation and lack of continuity in patient services and burn-out on part of the nurses still in the work force. Many have left the discipline altogether. Increasingly RNs are expected to manage the less skilled workers that carry out the hands-on tasks for patients and coordinate the patients' care. They themselves now perform only the most technically complex tasks on the run with little time for patient contact, what Davies (1995) dubs the 'polomint problem'. Simultaneously non-nursing duties, particularly paperwork, have increased, taking nurses away from the bedside even more. As texts in patients' charts (Campbell, 1992) are increasingly used to audit care, actual nursing practice thereby gets pushed to the side lines. Tovey and Adams (1999) list many of the same factors, such as increased paperwork, lack of job security and tight resources. In their studies of nurses' job satisfactions within the British healthcare system, they describe similar conflicts for nurses that result as resource constraints impact on their ability to provide quality care and force them to compromise.

The biggest concern is the nurses' lack of input into restructuring processes; their expertise remains unacknowledged, as changes are made, which are often impractical and sometimes absurd, leaving them increasingly disillusioned and control over their work slipping away from them. Restructuring of the system has become a beast that feeds on itself, creating effects which simultaneously exacerbate the existing situations even further. There is a whole 'ensemble of actions' (Foucault, 1982) that historically put nurses on the sidelines, and facilitated the recent events. Casualization has further reinforced this marginalization, as part-time workers feel less attached to any particular place and even their patients, whom they hardly get to know. To nurse the system back to health, the challenge it seems will be to show that quality of care and efficiency are not necessarily antithetical but really go together. Before that is possible, a (re)valuing of human care needs to happen. It must be understood that caring is essential to improved quality of life and can even lead to decreased expenditures on illness. The lack of nurses is beginning to be felt. There had been ample warnings about the impending shortage from nursing's professional bodies, yet they were not heeded as those who made the decisions barrelled on.

For Foucault (1982; 1980) power is seen as 'strategic games' amongst various players. It works through relationships, their 'agonisms and antagonisms' of strategies, the players' actions upon the actions of others, actual and potential. Everyone is always in it -- we can not not participate. Once this unavoidable involvement is understood, change is best brought about 'from the inside', at the local level, where the effects are played out. To better fathom the mechanisms of power, nurses' relationships, how they see their roles, and how they interact with the other players they encounter through their work are examined more closely in the next chapter. The second layer thereby uncovered should bring to light more clearly how nurses themselves actively participate, knowingly and unknowingly, willingly and unwillingly, in the relationships of power that shape the healthcare system.

## CHAPTER 6

### RELATIONSHIPS OF NURSES WITH OTHERS: STRATEGIC GAMES

#### Introduction

From Foucault's (1982; 1980) perspective, power always works through relationships and everyone involved is an active player and 'always already in it'. All relations are rooted in the 'system of social networks' -- the field of possibilities in a given society -- always building on already existing power mechanisms, extending them and transforming them (1982, p.793). The 'recalcitrance of the will' and 'the intransigence of freedom' on the part of all players renders power in this sense perpetually unstable. Power and resistance are inextricably linked and aspects of the same phenomenon; they exist as 'reciprocal incitations and struggles, a permanent provocation' (1982, p.790). Power therefore always comes at a cost, either monetary or social. The changes that occurred during restructuring have been shaped through and simultaneously reshaped the relationships between the players involved, as is shown in the previous chapter. To uncover the underlying dynamics of power / resistance I asked the nurses how they see and conduct themselves vis a vis the various groups of people they encounter at the bedside. I hoped that insight into these relationships will shed light on how the nurses themselves participate in the social construction of their own roles.

In the previous chapter I describe how nurses deplore having less time with patients, due to the restructured work organization. They maintain that patients come first for them. Yet the participants also relate instances when nurses fail to advocate for their patients, side with others in the system against them, or even chide each other for being compassionate. Their work is sometimes inappropriately delegated to families. Collegial relationships, although often still steeped in oppressive practices towards others, are beginning to be recognized as important. They regret that team work got lost to total patient care. They welcome better collaboration with other healthcare workers of the team, yet feel that nursing is often not valued. There are also complaints about the people in administration and their ignorance of nursing work and lack of respect for nurses. They perceive that business practices are increasingly used to run the system through centralized decision making.

To better understand what is happening and how it can be changed it seems therefore important to explore more closely these various relationships. As the second layer is pulled away the 'dividing practices', the 'systems of differentiation' (Foucault, 1982) between the nurses and others, come to light more clearly. I will start with the nurses' alliances central to nursing -- those with their patients and the patients' families.

### **Relationships with patients and families**

#### **Participants' perspectives**

It is very frustrating for them [families], because they don't understand...they have family members, I mean they want you to attend to their family member first. And I can't... and I wish that they could understand that, you know what, that is what is happening. I have just too many patients. No point going to tell them that we have too many patients and your father or mother is not important. No, they would not want to hear that. Consider their frustrations, just waiting. (Corinne)

I find people much angrier now because they have heard so many horror stories about health care. They have talked to friends about their experiences... so they come in and they are instantly angry... probably because they are scared. And that, in my mind, is too bad. Everybody is so busy, it is hard to deal with it adequately. A lot of the services that were there, are not there any more. Physio-therapists don't see them as routinely as they should, we don't use certain medications because they are too expensive. The place is dirty, because the cleaning staff is on lunch hour. I think the biggest problem is the anger and the fright. (Derek)

At the centre of nursing's work, its reason for being, lies the relationship between the carer and the cared for. In this section I am concentrating on how the participants are positioned / position themselves, knowingly / unknowingly, in relation to the ones they serve. I also explore further how the restructuring processes impacted on these relationships. All the participants state they greatly value their relationships with patients and families. In turn, recognition and appreciation of nursing as a valuable service is rated as highly important by them. They repeatedly talk about how the decreasing quality of patient care, mainly due to multiple demands on their time, leads to decreasing job satisfaction. In the last chapter ringing call bells symbolized

deterioration of quality of care.

Yet, despite many stated difficulties, all participants report that relationships with patients and families are generally good. They also believe that they could be better. Their number one complaint -- familiar by now -- is: "Not enough time to be with them". Corinne works on a busy floor. She states emphatically: "I think she [nurse] should have more time with the patient. I thought that is what I would have going into nursing, I would have time with the patients. You don't! I need a lot more time". She, like the others, seems very sensitive about criticism of her care and expresses frustrations over unsatisfactory relationships with patients and families: "...and their [families'] attitude towards you... Sometimes it comes to the point where, you know what? Not that I don't care, but what can I do"? Kelly, in order to counteract what she feels is undeserved criticism, tries to actively inform patients and families about the political implications of restructuring, "not to put fear into them, but...to be more understanding ... Because they have to see it first hand and understand it instead of being angry at us". As being able to help seems to provide their greatest source of occupational and personal satisfaction, caring often goes beyond the call of duty. For example some of the participants tell stories of regularly visiting former patients who transferred to different departments, as I had done in the past many times myself. Then there is Diane's example of sharing her own meal brought from home with the 16 year old who is living on the streets, which is discussed in the previous chapter. Yet, on the other hand, we have seen that there are colleagues who disapprove of being compassionate.

It comes as no surprise that the nurses feel that the busier the unit, the lower the quality of the nurse-patient and nurse-family interactions. Sonya was hired after her last placement in an unit where the staffing is relatively good. She reports that she is quite content working there. It seems that families and patients appreciate the care they receive:

The families were very understanding, actually. They understand that there is restructuring, they understand that nurses are under a lot of stress, and...that there is...a lot of changes going on. In general they were not expecting extras, but they were expecting adequate care, good care. They were not complaining. I think... most families and the public really respect the nurses and what they do. They say how they really appreciated our help and what we do. They know how much work

we do, because families have said that to me.

Most others are not as positive. Bruce works in a unit that is quite short staffed. He contemplates the difficulties that are affecting the expectations regarding the nurse-client relationships. He fears that understanding and patience on part of clients have their definite limits:

Well there is a paradox here. I know the nurses' relationships with the clients and their families is intense. I listen to nurses talk so much about the relationships. I think nursing is still highly regarded. But, at the same time, I do fear that people's experiences of patient care are sometimes not very good...and it is due to the nurses experiencing shortages. ..But, this excuse of, 'well, we are short tonight', wears thin after about the third time. Initially, if they sense they are busy, people understand that....but now, it becomes too much. So there is another paradox here: admiration for the profession, yet frustration with the care.

Kathy animatedly relates how stressed patients and families are and the severe demands that are thereby put on the nurses themselves:

Before I used to come across so many positive people, there were not as many complaints back then, whereas now, everybody complains, right when they come through the door...everybody, patients, families, I don't find it is the patients, it is the family...you know their rights, everybody is crying rights, my rights...and you just have to bend over backwards to accommodate them. When someone is sick they want something right now! Now, now, now! Sometimes these people, these families are really aggressive! Assertive, aggressive! Oh I know, because I think if I had a family member in the hospital, I would be there all the time too. But, on the other hand, I know how nurses feel too.

Derek, who also works in an institution where severe cut-backs of staffing and other necessities have been implemented, reports frequent unpleasant incidents which he believes to be the results of fear and mistrust on the side of patients. When asked if patients vent their anger on the nurses, he responds: "Always, always... because we are the people they deal with and it is only natural. I work 12 hour shifts and am the person for 12 hours spending time with the patients". He too feels that in general nurses are respected by the public. But this respect is not a given, it has to be earned first, which he finds is not always easy under the circumstances.



However, when needed and received, Derek feels that nursing care becomes visible and is appreciated but also expected:

I think yeah, once they have had some dealings... I don't think the public really knows what nursing does. Once they realize the scope of our practice and what we are capable of doing, and what we actually do... everyday... that changes. I think most people come in angry, are really scared... frightened, and by the time they leave it is somewhat better. They are probably somewhat satisfied, because, as I said, the place is still dirty, still not enough staff. But I think their perception of nursing is maybe a little better.

In the midst of daily turmoil, feeling overwhelmed, Samantha tries to draw strength by focusing on those relationships with patients that are good:

Even though I feel frustrated a lot, I don't show it to them [patients], like I still keep it in...I know I do make a difference with my patients. Even the families do appreciate me, they always compliment me... I have gotten a lot of gifts from families after patients have died... I really do it [show my emotions] when I leave the room, or sometimes when I am really angry I just go to the bathroom and I just...calm down for a bit. Not that I am mad at them, I am just frustrated... I have just [too many] people speaking and asking me at one time, I have like 5 patients asking me different things, I have health care aids asking me... if I am facilitating I have emergency calling me every second...there is just so much stuff at once.

Esther seems more laid back: "For me personally, I have hardly had any problems as a result of this. Ah, most of the time if there is conflict, let it go". Carol too has learned in her long career that not all relationships can be good ones. "I think it depends on the individual. I have had good and bad experiences with patients and their families. I have a lot of good ones that are memorable..." She too focuses on those good memories to sustain her. She talks excitedly about how her brother, who lives in a different province, recently met a business client from an area close to Toronto. "It turned out that I had taken care of his son on home care. So, there is someone across the country who has met a family member of mine, who was happy with the way things went and remembered me as a nurse...and that is always a pat on the back", an example of the importance of recognition by those they labour for, even for the seasoned nurse. She also talks about 'letting go' when there are disagreements, as she has learned it is impossible to get

along with every one equally well, no matter how hard you try. She believes that it is most of the times not because a nurse is perceived as incompetent but more due to a personal conflict, hence not necessarily a reflection of the nurse's ability to provide good care:

I think the majority of my experiences have been positive. There have been the odd ones that were very negative in the sense that... you just did not click! click as a relationship. Just something happened and you did not click with the family member, or with the patient, and you just did basically what you had to do, and let it go. I do not think that it has anything to do with nursing itself. I think that it has to do with the person who is the nurse. I mean... we are all human beings first and then we are nurses. And if you don't remember that then you are in trouble.

Danielle seems to agree. She looks at ways how nurses can help each other in these situations. If there is a difficulty in the relationship between a nurse and a patient, she feels that a change in assignment is often helpful, in order to separate the parties. With mutual support and a collaborative approach amongst colleagues she believes this type of difficulty can be overcome:

So, we are just trying to help each other out, pick up where someone else had interacted well and try to get somebody to help them vent their feelings...So, I guess that is something that is learned through the hard way. After years of these problems we start now to realize, maybe we don't have to cope with it all by ourselves and maybe we should say something and let someone else come and take the heat off.

Sarah brings up another factor in the nurse - patient communication, namely that the patients who complain a lot usually get better treatment, even though it might be rendered grudgingly:

So, in some particular cases there are just people who make more demands, it is almost like who squeaks the most gets taken care of.... and then you have nurses on the unit where you feel there is just not that caring, that understanding. Yeah, the squeaky wheel gets too much, yet they don't get the caring...they might get the smile on the face, but it is not a sincere smile.

Sarah further points out that not all her colleagues are dedicated to the same extent. Even though they complain about not having enough time for their patients, the same people may sit on the

desk and talk with each other on occasions when they are not busy. Sarah interpretes their behaviours as a sign of their “emotional immaturity”.

## **Discussion**

The participants feel they deserve to be appreciated for what they do for patients, hence expect and value positive feedback. Good communication with patients, to be able to help them, are probably the most important factors that lead to job satisfaction for nurses. It seems that people are giving little thought to nursing until they need the service. This speaks of the relative ‘invisibility’ of nursing in our society, where the spotlight is on ‘curing’ and high tech diagnostics and treatments. Then there is the reluctance for most people to concern themselves with suffering and death, processes which largely take place behind the doors of institutions. Yet, once received and recognized, nursing services seem to be generally valued by the recipients, but also expected. While the increased work loads leave less time for caring and cultivation of the relationships, the patients and their families still feel entitled to the best care and individualized attention. Fletcher (2000a, p.20) claims that “consumers consistently rate nurses as their most trusted source of health care information and the most trusted health care professionals, in public opinion surveys. Yet there doesn’t seem to be public will to demand quick resolution of issues...”. To educate the public about nursing, as some participants suggest, is probably the best strategy in the long run.

Due to the importance these relationships hold for them, most nurses continue to go out of their way to live up to their own high expectations of themselves. Through empathy and compassion situations of families who are worried and demanding still get mediated and accommodated most of the time. Nurses thereby facilitate their own exploitation by others within the system, as they try to stretch further on cost of their well-being. It is their wish, as well as their felt duty, to provide good care to patients, but also their Achilles heel. Fletcher (2000a, p.20) points out that their dedication often leads nurses to neglect themselves and everything else, as they go out of their way to ensure patients are well cared for. She cites Judith Shamian, Health Canada executive director of nursing policy, who states that “nurses can be their own worst enemies”, as they do anything necessary, such as working extra shifts or coming on duty

when not feeling well. This is what keeps the system going despite all the cut-backs -- yet it comes at the cost of nurses' health, as their high sick times suggest.

Participants discuss the occasional clash of personalities between nurses and their patients. While the new nurses take criticism very hard, more senior nurses seem to have learned not to interpret occasional difficulties as personal. One experienced participant suggests reassigning nurses and patients when there is an incompatibility. This 'matching' of personalities points once again, to the importance of working together. It also shows an emerging recognition of nurses' own humanity versus the depersonalized image of the 'nurse is a nurse is a nurse' that has long prevailed, especially within nursing's own circles. Even today nursing textbooks still read that 'in such and such case the nurse will...' implying that all nurses are the same. This reification creates unrealistic expectations. Nurses, like patients, are individuals whereas in the health care system they are treated as 'stylized' nurses caring for 'stylized' patients, according to Foucault a 'totalizing practice'.

Some patients are seen as manipulative in achieving what they want and by complaining might get better care than others. They and their families are positioned in the 'restructured' healthcare system as 'consumers' responsible for their own health (Peterson & Lupton, 1996). It is therefore not surprising that their self-styling includes assertive consumerism and advocacy for themselves. For nurses to give in to their demands is probably the easiest way out. It is also a mechanism to reinforce the status quo, as it helps to make the system work. The patients who have the loudest voice to complain, perhaps rightfully so, direct their demands to the nurse as the 'immediate enemy'. Yet the 'chief enemies' (Foucault, 1982), who often are found higher up in the system, never hear about it. However, sometimes patients might also be complaining because the nurse really is uncaring, as is also observed by Sarah. Even though the nurse-patient relationship remains important to the participants, not all opportunities to provide patients with the best possible care are always grasped by all nurses. At times their own needs seem to override their commitments to patients as they do not, or perhaps can not, give 100% of themselves to their work. As the nurse-patient relationship is intrically linked to how nurses conceptualize themselves and their practice it will further be examined later.

The institutional culture seemingly promotes autonomy and self reliance, yet expressed in

specific narrow ways, such as the 'total patient care' concept, whereas a team approach towards patients is often better, as personalities can be matched that way. Indiscriminate cut-backs on staffing without regard for nurses as human beings are taking their toll. That many nurses are getting disillusioned is perhaps not really surprising, especially when public respect is not always received. With no time for breaks and no place but the bathroom to have a moment of privacy inbetween, nurses feel they are 'doing good, but feeling bad' (Acker, 1999a;b). Fletcher (2000a, p.20) reports "a keen sense among nurses that they've been taken for granted for decades". In addition not every nurse is caring or ever will be. They are real women and men, not saints, and therefore have to be distinguished from the 'ideal nurse' as a figment of wishful imagination. The nurse-patient relationship remains the heart and soul of nursing. However it shows signs of being stretched thin and cracking in places. Ways need to be found to make this relationship work better -- more effective for patients -- that simultaneously preserve and promote the nurses' own well-being and job satisfaction. Relationships of nurses with other nurses, which hold the potential for mutual support and 'strength in numbers', are discussed next.

### **Relationships among Nurses**

#### **Participants' perspectives**

It does not matter how much work you have to do, that is not the problem...I think it's accountability, like people are just not accountable, not responsible! It's just, there is so much of this 'sloughing off business'... like come and help me, I don't want to do this or they don't do that...come and take over! Somebody always has to take over. (Kelly)

The support of nurses by nurses has grown. The last two years have been a real eye opener for nursing. They found that this [support] role was not coming from the institution, it was not coming from the managers, so it has to come from within. So it is from colleagues at the same level. (Anna)

The above quotations point to the significance of collegial relationships to the quality of the nurses' work lives. In the previous chapter we see that collegiality and teamwork, as well as mentorships of new nurses, is made very difficult due to the reorganization of the institutions.

Stable teams have all but disappeared, as most nurses work casual, providing 'total' patient care for one shift at a time. Sarah describes how it is difficult to communicate when nerves are already frayed in an atmosphere of stress: "I think in terms of how they [nurses] talk to each other sometimes...I know that one or two on the unit, you say something the wrong way, you just have a big backlash...You did not mean it that way, but sometimes it comes out the wrong way, because you are so frustrated". Assignments that are perceived to be inequitable, are often the trigger of problems. When two new beds were added on Sarah's unit, "it resulted in friction among staff... who would take one extra patient". Add to the resulting increase in work stress the historical hierarchies and divisions within nursing, and it could be expected that work relationships are at an all-time low. Kelly's quotation above seems to confirm this assumption. However, Anna's comment conveys that restructuring was, at least for some, an eye opener about the importance of mutual supportiveness.

Who you are working with is rated as important by all the participants. Kathy states: "Being grouped with three other people I don't enjoy working with... I would be miserable". Jennifer seems to agree: "Sometimes you get put with someone and it's just...it's like opposite poles of a magnet. It just does not go, no matter how you try, it just does not go...". Jennifer, due to her position in a 'stable' working relationship, appreciates her present co-worker: "I get along very well with my [working] partner, thank God. I think the two of us keep each other going, because we are like all we have", once more pointing out the importance of good working relationships.

Traditionally nurses are known to 'eat their young' as is repeatedly mentioned by several participants. Esther makes the following observations about the lack of welcome extended to newcomers in general: "Because I find that if there is a new nurse, that nurse is not just going to pick it up. She will say that floor is too heavy. Even if they [nurses] see it, they often do not do anything about it". Ronnie feels that there are limits, despite best intentions, how many new staff a unit can take on at a time. As freshly hired employees are unable to carry a full load for a while and need extra help, there is more pressure on the established nurses, she explains:

I am finding that I get along well with my colleagues, on the whole, yes. On the whole they work well together. Except, just recently they hired a lot of new staff,

we hired nine new staff. And some of them have no experience in emergency, so that makes it difficult. Especially when you are short staffed. You have only two senior staff working with two brand new ones, that really, really makes it difficult in the department. And, I think this is a bad time to happen too, when all this new staff came in the summer. Some of the staff are on vacation, so that is a bad time.

With her student experience just behind her, Sonya believes that she sensed “a stress, a resentment kind of... to students” in many settings. However, at the last hospital where she got hired and where the staff-patient ratio is fairly good and support services seem adequate, she finds that things are better, linking workload stress and collegiality:

...everybody was pretty much equal, except for experiences. The preceptors would teach but they would respect us. They would teach us, but not look down on us. But at other institutions it was different. They were...resentful of us being there, and it was just too much work, extra work... especially at hospitals where they have 7 or 8 patients or more and they have to do everything...and then plus they have to take on a student. And that really slows them down. But at this hospital it is very different, because we only have 3 or 4 patients. And there is a lot of other workers there too that do the cleaning, do everything.

Anna, herself an experienced nurse, also acknowledges the lack of support for new members of the profession: “I feel sorry for the younger girls that are coming in right now, there is no nurturing. You are just thrown... do what you do and deal with it. That is why nobody wants to join and those who are joining are leaving so fast now...”. She too believes that there was more guidance before. An urgent need for mentorship is also identified by Harrison and Reid (2001) who, themselves recent graduates, experience little support from their colleagues.

Samantha, a new nurse who works in a ‘team’ with unregulated workers who are doing the hands-on care, discusses her relationships with her colleagues on the floor: “Actually I get along well with others, I never have gotten into arguments or fights with anybody...there is nobody there that I really don’t like...”. However, she further relates that, afraid to be a bother during busy times, she is often reluctant to ask for information or help. She admits her timidity leaves her struggling to find out what she needs to know on her own: “But the RNs, even though they are busy, when I do ask them for help, they always stop and help me...It is more me, I am

feeling like a bother...like I sometimes don't ask...if it is something of an emergency, when a patient's health is at risk then I will ask... but like something that can wait, I don't want to bother them...".

Not only are new nurses left struggling because of their own reluctance to seek help, they are frequently also ignored, rejected or domineered by their colleagues. In one of Diane's previous work places, a group of newly hired nurses questioned some of the non-nursing tasks they had to perform. They felt them to be demeaning to nurses and sought to improve everyone's working conditions by refusing to carry them out. Yet the 'old' nurses resisted their efforts:

...because there is a big influx of new nurses, they are being judged as not good nurses. It does not mean they are not good nurses, but because they are going: 'you know what, forget that, I am not cleaning up. Sorry, but my job as a nurse is not to sit here and pull laundry out in a laundry basket and carry it down the hall...'. Now, God knows, I have done that, because I can't stand looking at it. My job is not to clean up garbage and we have people established who do that. I am not going to say that, if the garbage is falling out of bins on the floor, I am not going to clean up. But they are not paying me...to do somebody else's job that is not doing it properly. But the new girls that are saying, that is not my job, when they have every right to do that -- a little pat on the shoulder for them -- now all of a sudden they are just terrible nurses, they are not doing their job properly.

Diane recognizes these practices as a form of abuse: "We are harder on ourselves than anybody else. I have seen people leave because they have had so many nasty things happen to them".

Hilda, an experienced nurse, also tells a story of not being welcomed in a new unit. She recounts how she had lost her own position and was forced to bump another nurse out of hers. Her colleagues in the new department refused to help her during her orientation. At first she thought it might have been out of solidarity to their displaced colleague that the nurses gave her the cold shoulder. The major reason however, as Hilda eventually found out, was that a physician there had objected to her predecessor's lay-off. One of the nurses eventually told her that, out of loyalty to him, they refused to accept her. With all this anger directed against her, she was unable to bear the resulting stress. She quickly jumped at an upcoming opportunity and applied successfully in another department.

Jennifer talks about similar difficulties she and her current co-worker had experienced,



when they first started in the department. The senior nurses there felt entitled to 'pull rank' on the two new ones, seemingly to assert their privileged positions. They ordered them, "to do the work while they relaxed on the desk". Yet they refused to share their knowledge with the new-comers and gleefully watched them founder. Jennifer interpretes her experience of hostile reception as specific to women:

But this is the kind of thing they say nurses get on each others' cases...The nice thing would be if there was no pettiness, of this holding back... I will not tell others this, it is my own little, personal pool of knowledge...because so and so will steal the glory or whatever...like sometimes the pettiness interferes from one shift to the other, or one person to another, so that is where you get into the business of all the backbiting amongst nurses. It is not because nurses back bite, it is because you have a whole bunch of females working together and there is a personality thing.

She concludes that she favours the idea of more men in nursing to improve the climate.

Sonya too attributes some nurses' unsupportive behaviours towards each other to a commonly held negative stereotype of 'femaleness'; yet she also has some ideas on how to promote mutual supportiveness:

I would like to see nurses in general, that the nursing profession would be more together and nurses would not be against each other... Do you think it is because they are mostly females? (My question to her: Do you?) Oh, sometimes I think so...Females just talk a lot...just talk a little too much... one thing I don't like about nursing is that...during break they always say things and always negative things about each other. I think if everybody was a little more positive and spoke about positive things, nursing would be more positive. I think there should be a rule that for every bad thing that you say, you have to say something good about what she did. I think that would help to stay positive. Or even just trying to find something good at the institution.

Kathy believes the poor relationships exist because there is not enough guidance and evaluations by superiors now: "...you are being critiqued, positively and negatively and I think that is good, we don't get enough of that now".

New nurses everywhere seem to encounter problems with being accepted. Baccalaureate prepared new graduates, however, are rated overwhelmingly as the 'worst prepared' by the

experienced nurses. Sonya and Corinne, both university educated, are convinced that having gone through a degree program, was a major reason for lack of support from other nurses. Sonya had experienced that nurses in many settings refused to be helpful to students, particularly those in a university program: "They are more like... you are the student, you should know what you are doing...So, I let you do it. You do it!". Corinne talks about how, in self protection, she learned to hide her educational credentials from others:

I never mention it to them that I am a degree grad. That is the best. So I can ask a million of questions and not feel like a fool... Yes I have had nurses tell me to my face, that university graduate nurses...can not do good bedside nursing...and you are an RN and you are from a degree program and you don't know that?!! I guess they felt threatened that by the year 2000 you have to have a degree [now 2005].

Both feel good about their education. Corinne, in turn, counters with how some of the diploma nurses perceive their roles as performance of tasks. "But also what happens is, the older nurses are finding it very hard to adapt to changes. There are a lot of issues...". She sees their frequently narrow focus on skills as limiting and believes that the nursing profession will be able to make better contributions to health care with the much broader knowledge base acquired through an university education:

The three men in the study state that they get along well with their female colleagues, even though they see them as lacking involvement in workplace issues. They recognize that they themselves are generally advantaged over the women, many of whom are the main care givers in their families. Often they are also the main breadwinners; some of them are single mothers.

Bruce explains:

Women are still the primary nurturer, care givers, the glue that keeps the family dynamic together... when they are trying to juggle a professional job, such as nursing, they don't always have the time to be going to these inservices (equated with continuing education)...what happens over a course of time, they get into their rut, their niche and they don't know anything else... I guess they lack not self esteem, but self reliance.

Jack is convinced that more cohesion between nurses would improve their situation. He himself

is also a member of a male dominated trade union, as he holds a second job. He blames the lack of unity not on gender, as did some of the female colleagues cited earlier, but on educational and organizational changes that have led to the loss of 'team nursing' and 'camaraderie'. He believes that togetherness of nurses had been good when he first joined the discipline -- it had been drilled into them during nursing school -- but now it seems forgotten. He wishes for nursing education again to emphasize cohesiveness and team spirit: "You can inculcate that right in the beginning, right when they start in nursing school the standards, the excellence, esprit the corps, the camaraderie, the support, the teamwork... And again pride... you start in the beginning then that carries itself all the way through the profession until they retire". Shelly seems to agree that more emphasis on camaraderie is urgently needed: "Ahh... I remember when I was in school they really pushed the idea that we were patient advocates. And that is all fine and well, yes we are, but I think we need also to consider that we are nursing advocates as well. You know, because I think that got left behind".

Carol's solution to deal with relationship problems is trying to work together, putting personal differences aside. This approach of 'self preservation' she feels has helped her, as the career she valued had required her to work with many different people and usually in high stress areas:

In general I get along with almost everybody I have ever worked with...and if I was not getting along or I was having a difficult time with that person, I have always tried to fix it or tried to ask what the problem was. If I was not able to do this, then I just pulled myself out of the relationship completely and basically just did what I had to do. Like if I was working the same shift as them, then priority became the patients....If there was a personality problem then I was mature enough, hopefully, to let it go, and not to let it affect my work. And...I always tried to come back to why I was there in the first place.

Esther, a diploma nurse with many years' experience, recently took a leadership course. The knowledge she acquired, she believes, is helping her to become more aware of some of the underlying issues and how to deal with them:

It is crucial that we pay attention, watching out for the other person and what she is doing. You can see who is helping and who is not. I think it happens

everywhere, not just in nursing. As nurses we should be caring for each other, but sometimes it gets forgotten. So, as I say, we should be looking at everybody's work load. There are times when the assignment is wrongly distributed and needs to be changed. And not only changed for one, but changed for everybody else. So, I have started speaking up. I am not pointing fingers, but pointing things out, and say: 'look, I came on shift and I see that the assignment is not fairly distributed. I changed it, because I checked and I see you have a light assignment vis a vis another nurse who has, maybe, two heavy patients, and I give you one'.

She believes that nurses' desire to please others often interferes with their ability to be assertive and stand up for what they believe:

Of course, who is unfair, will not like it. But then, to be a leader, you have sometimes to be a martyr. You can not always be popular. Many times other nurses see you and say thanks, because it takes guts! As a nurse sometimes you have to step on toes, you are not there to make friends, to be friends with each other, we are there to do a job...I have been saying this, if you want people to stay, you have to share the workload. It does not mean that you have to work together together... You will have your patients and I have mine. But you have to be prepared to help each other and listen to each other. So, this is something that I am working on...we need to change and changes are made, we have to expose certain things. If you are not happy with something, say it. There is no point sitting there complaining and stewing.

She too advocates for mutual support in nurses' working relationships with each other, which she believes can be learned.

On a more positive note, several participants exhibit increasing awareness that nurses themselves have to try and take part in their own destiny. Ronnie relates her experience of being laid off and having to 'bump' a nurse on one of the floors. She was warned in the human resources department to be prepared for a hostile reception by the nurses there, as they would be upset about their colleague's displacement. Unlike in Hilda's case discussed earlier, she found that the nurses on the unit welcomed her warmly. They told her that no one blamed her, as they recognized the transfer was a management decision and not her fault. Even the nurse she displaced showed no hard feelings. She herself, in turn, had bumped someone else out of her job. Several other participants talk about similar experiences. They, like Kelly, believe that nurses finally are realizing, that "we are all in the same boat", and that there is "strength in numbers".

To promote being more comfortable with each other Samantha brings up the example of a pot luck dinner the staff recently put together, “which just made everyone happier and everybody was just joking around with each other and that brought people’s spirit up. So we could do stuff like that...”. She feels it to be very beneficial for colleagues to see each other “in a different light” outside of work. Anna works in a special unit where the relationships also have moved beyond mere self preservation towards mutual support. Her quotation at the beginning of this section conveys this new-found awareness of solidarity. To further better relations she, as well as Kelly, also mention that they socialize more with one another after work. They now have begun to support each other regarding stressors in their personal lives as well, like deaths in the family, sickness and divorces and feel that they thereby have become more cohesive and collaborate more.

Mutual support, where it does exist, still is felt to be exceptional rather than the norm. Danielle: “I think we are quite good about helping new people come in and orientating them...I have been there for a long time, I am not the one coming into a new situation. I think I feel that people generally get along, which is not always what we hear from other places”. Derek too finds togetherness is improving in his workplace: “I think we have been lucky. In our area restructuring has brought us closer together and we have become a more cohesive group. And I work with some really intelligent, compassionate, great people, I have been really lucky”. Asked if there is mutual support, he states: “Oh yeah, very much”, then adds cautiously: “I don’t know if that is the norm, I doubt it”.

## **Discussion**

The most frequently voiced complaints by the interviewees regarding other nurses are about non-supportiveness of each other. Whereas caring for patients is a given, caring for colleagues remains an exception rather than a rule. This comes as no surprise as in my earlier study (Daiski, 1994), I had found that, although other nurses were considered a great source of support, they were simultaneously also rated as one of the biggest sources of stress. The negative effect was mainly due to ‘backbiting and talking behind closed doors in the coffee room’ about each other. These behaviours achieve some temporary relief through venting of feelings but leave

conflicts unresolved and keep nurses divided amongst themselves. Nurses are also known for 'eating their young', a metaphor that was cited by almost all of the participants at some point during the interviews. As expected, for the most part, the high stress caused by current job insecurities and increased work loads seems to exacerbate competition and 'oppressed group behaviours' (Robertson, 1983; Valentine, 1991). Adding to these tensions, as discussed previously, is the trend towards casualization. As the new 'teams' are mostly temporary rather than permanent, there is no time for staff to get to know each other and integrate new members, especially as in many places there is no longer a common report time, when connections and arrangements for mutual help can be made. The concept of total patient care that emerged from restructuring leaves casualized nurses working on their own.

However, not all interpersonal problems can be blamed on the recent developments brought about by restructuring. What seems the case, though, is that existing rifts have become exacerbated. Nurses are haunted by the legacy of nursing's hierarchical organization. As the literature review has shown, many divisions were present within nursing from the start. Foucault predicts that contemporary patterns of relationships articulate with past long established, as well as current ones, and further extend them. In the preceding reports we are able to identify several mechanisms through which power is exercised amongst nurses, and which simultaneously preserve the status quo -- basically they are bullying tactics. Established nurses on an unit, for example, often give newly hired nurses an unwelcoming reception. They act in this way not only out of resentment towards the added workload of training them, but frequently because they try to assert their own superior status through putting the newcomers 'into their places'. However, when the new people are leaving, it does not improve the staff shortage on the floor. Disillusioned many young nurses get out of nursing altogether, some never even get started, a trend discussed in the last chapter.

Diane's story about her colleagues' resistance towards new staff who tried to refuse to carry out certain menial tasks, shows how these relationships are self defeating. Probably the nurses there had taken these practices for granted over time and were accustomed to them. By upholding them they saw an opportunity to shore up their own positions in the established hierarchy and to 'pull rank' on the new-comers. Diane's account is very congruent with my own

experiences in places where long-time staff with strong personalities and opinions set the tone. There is often a constant scrutiny and criticism by the existing staff of new nurses, designed to make them 'fit' into the workplace culture. No matter how competent the new people are, they can not do anything right. The 'good' nurse is the one who accepts her/his place in the hierarchy and learns to do things the 'way it is done here'. Thereby the status quo is perpetuated.

Vying for approval of the dominant groups, such as physicians, is another scheme used by some nurses to reaffirm their status, even if it means turning against other nurses. It represents a common strategy of 'oppressed groups' (Robertson, 1983; Valentine, 1991). Hilda's experience, when her colleagues sided with the physician, is an example of this custom. It is not only damaging to nursing's own cause, it also simultaneously perpetuates medicine's continuing influence over the nursing discipline. Staffing, officially an internal matter of the nursing department, lies clearly outside of medicine's domain. It seems that the nurses in this example failed to see that their alignment with medicine is also reinforcing nursing's submissiveness and dependency.

Another strategy is the withholding of knowledge from other nurses, such as in Jennifer's experience. The established nurses not only try to ensure their own superior status, their refusal to share what they know might also satisfy a desire to provide better care than anyone else. This desire is evident in many statements about how good it feels, when a patient says something to the extent of 'you are the best nurse I ever had'. In most cases this kind of praise represents a very innocent reward, a 'pat on the back' for the nurses who take pride in their achievements. Yet some will go as far as not sharing important information, to make it difficult for others to 'measure up' to them. Such behaviours fail to serve their patients and could even be detrimental, if vital data are withheld. Christina Hurlock-Chorostecki's (2000) description of her own experiences of non-support, when she was bumped recently, also confirms this ongoing lack of solidarity.

Samantha's situation is an example of how working in isolation is most problematic for new graduates. Working in a 'team' with unregulated aids whom she manages, she seems not to experience any of the customary power struggles with other nurses. Yet a strong unspoken expectation of self reliance also seems to keep her from seeking help. Her experience shows how

the discourse of 'autonomy', narrowly interpreted as 'total patient care' by following routines, interferes with nurses mentoring each other. It leaves the new nurses without guidance and works against a more unified stand amongst the discipline. The brunt of unsupportiveness, however, seems directed towards new 'degree grads'. As Corinne suggests, it seems reinforced with the future threat of baccalaureate prepared nurses taking away jobs from experienced diploma graduates, as a degree will soon be the entry to practice requirement. Even though previous diploma graduates are supposed to be 'grandfathered', they may fear being displaced by baccalaureate prepared nurses, or at the least miss out on promotions and opportunities. The issue of educational requirements will be more closely examined in the next chapter.

Kelly's quotation in the beginning of the section about the common expectation amongst nurses that 'somebody always has to take over' shows that reliance on others, who are perceived as more capable, persists. Few nurses seem to use open communication with their colleagues if problems arise. Some participants use the discourse of the 'catty' female stereo-type as an explanatory model for nurses' non-supportiveness of each other. Nurses frequently wish for 'more men in nursing' or their unit managers to 'fix' their problems, also shown in my previous research (Daiski, 1994). Kathy seems to ask for tighter external control and supervision of individual nurses. As she had not taken any educational upgrading apart from specialty courses, she proposes a recourse known to her, a return to the 'good old days'. With the move towards professionalization and accountability for one's own conduct, control in recent years has become more an issue of 'self-government' for nursing. As an example the College of Nurses now requires all members to do an annual self evaluation, which should be supplemented with a 'peer' evaluation from another nurse, as a prerequisite for registration. Farrell (2000) describes self and peer 'surveillance' as discursively constructed controls over a contemporary worker's identity as a professional, who is cast as an 'independent human being' and whose work becomes his/her persona and essence. 'Reflective practice' implies that continuous 'learning' takes place, as learning is considered the "work practice that will revolutionize business" (p.18). In the end any form of self-regulation, according to Foucault, is a more subtle form of 'governmentality', a more covert form of surveillance of a profession's members. At the same time, at the practice level, administrative control is said to have tightened rather than loosened (see chapter 5),



showing that various technologies of power, old and new, are at work simultaneously.

While 'oppressed group behaviours' and vying for power positions inside of nursing continues in some settings, in others the hardships the nurses experience seem to act as a wake-up call, as chance and how discourses are taken up locally are always factors preventing predictability of events. Several participants talk about recognizing the importance of mutual support and discuss strategies to improve it. There is an emerging awareness by some about the dangers of withholding knowledge and other practices to maintain hierarchical relations, as they stifle change, reinforce the existing inequities, and keep nursing locked into its submissive position. Fletcher (2000a, p.22) confirms that nurses' awareness regarding their capabilities, especially through concerted action, is slowly increasing: "Young nursing graduates show none of the reticence that characterized earlier generations: They are not content to be the selfless handmaidens of health care". She claims optimistically that the job actions in the past few years taking place all over Canada, show "a unified, strong, collective voice, as never before, of nurses banding together", an example of the productive form of power. Esther's new-found capabilities of handling difficult situations after she took a leadership course seems to confirm that education and increased involvement in day to day activities on the unit is a worth while endeavour for all nurses, including those already in the system. It can open up new ways of envisioning and pursuing changes.

The emerging solidarity has the potential to facilitate 'change from within', an important strategy that could realign power relations at the local level. Overall, it seems, that better awareness and understanding of the various power mechanisms might lead to greater unity and render nurses less vulnerable to strategies of domination and exploitation by others, as it opens up new ways of understanding what is, but also what could be. Interdependence, although often discouraged and devalued, is perhaps the best form of resistance as the discourse of professional autonomy seemingly has been 'colonized' by the managerial discourse narrowly interpreted as 'total patient care' to promote casualization, and exploited for 'efficiency'. To improve nurses' work lives means to recognize and counteract the many current self-defeating strategies, and to explore the possibilities arising, such as from 'strength in numbers' to stand up for themselves and their patients. Next to be examined is the relationship between the nurses and the

interdisciplinary teams. Most interesting is the tie between nurses and physicians, with all its historical baggage.

### **Relationships with the Inter-disciplinary Team**

#### **Participants' perspectives**

Regarding other professionals I noticed we are a lot more aware of each other, we each impact on each other like dominoes. They realized we can not work in isolation...we can not go and hide in a corner while things happen, they actually are beginning to support each other now. (Kelly)

He (physician) is the type that will never know your name...he will never know it, because you are basically a non-entity to him. And that was her[a colleague's] measuring stick on whether that person respected you as a nurse. You know what, she is bang on the mark. (Shelly)

Working as an 'inter-disciplinary team', whose members were described in the previous chapter, is greatly emphasized in the restructured system. As healthcare institutions are becoming more outwardly democratic, many hospitals reorganized under 'health groups' in which all the healthcare employees are working together in a given department. Until recently, physicians had been the uncontested leaders of all the other 'para-medical' disciplines, who were seen as their support workers. Not wanting to endorse the notion of special status I asked about them in connection with the rest of the healthcare team. Generally working more closely with other disciplines is welcomed and is cited as a positive effect of restructuring (see chapter 5). Most participants, like Samantha, "never noticed any bad attitudes between RNs and them [team members]".

Kelly's comment above shows collaboration at the bedside leads to support amongst the disciplines for each other. Corinne explains: "The respiratory technologists come in, you can talk to them and they are fine. And the physiotherapists, they are always on the floor, walking patients". Danielle believes these closer relationships lead to greater respect for nurses' knowledge: "The team, they come to you for the information, you are there more times than anyone else. Yeah, I think they realize that we are there the majority of the time and we may know things...as far as I can tell, they respect what knowledge we have". Bruce shares some of

his insights. He believes that, by working more closely with the team, nurses' roles are not only clarified for others but also for the nurses themselves: "There is definitely a distinction, becoming more noticeable [between] the way a nurse approaches things and the way a doctor does. We know it in our hearts and we see it and understand it somewhat -- still not sure how we do it differently, but we know there is a difference...it's hard, we are still working on it".

The enhanced understanding of each other's roles contributes towards being comfortable with each other. However, it does not necessarily lead to more autonomous practice for nurses, nor to an increase in advocacy for patients, as Bruce explains:

Because the nurse is part of the team, it is good...but that he or she aligns herself with the client and not the team, which we initially thought that would happen, but it has not [happened]. So, the nurse is still very much a team member and espouses the team's values and directions. Very few times do you hear a nurse say: 'This is not what should happen, because this is us [what we want as a team]...she [the patient] wants to do it this way', I think we need to try that.

Bruce believes one of the reasons for this lack of advocacy on behalf of patients is the current bed shortage. He feels it is hard for nurses, under pressure to make room for other patients, to stand up and represent those who need to stay longer. Secondly, he observes, even with opportunities for input and leadership, nurses tend to go along with what others say. The reason, he believes, is that nurses remain unsure of their own worth and rely on other 'experts' to make decisions. The familiar strategy is, once again, to let someone else take over:

They fail to trust not only their intuition, but their knowledge level and understanding and their own relationships with the clients. They admire other professionals. Yeah, there is opportunity to say what you feel...but nurses still like to align themselves with other disciplines, they don't like to be unique, they don't like to be separate, they don't like to be original...nurses in hospitals have difficulties, I think. Going back to what restructuring has done to nurses...it has made us more cause-effect nurses... we are not happy with ambiguity...so we align ourselves with the social (natural?) sciences, as opposed to humanities...we have got a problem here, let's get Dr. So and So to look at it. Dr. So and So says, he has found the difficulty and everything is going to be just fine. And nurses buy into that...they are tempted because it is easy.

It seems that working with other disciplines has improved work relationships amongst the team, despite that nurses often have problems to take a diverging stand when indicated. As nurses are now supervising lower skilled workers, I ask about these relationships. Samantha, who is teamed up with unregulated workers in her setting, has mixed feelings. Several times in the interview she talks about how she resents these workers' closeness with patients as they are the ones performing the hands-on care. They thereby get to know the patients well, who confide in them rather than the nurse. She also feels having to rely on their reported observations is a matter of sometimes dubious trust. As they are 'unregulated', their knowledge, reliability and willingness / unwillingness to collaborate she finds varies widely; yet she as the nurse is the one responsible for the 'managing' of care, including their actions. Corinne has similar concerns. In her setting she is teamed up with RPNs, who have a standardized knowledge base and regulated practice, even though their training is much shorter than an RNs. Both participants are also relatively inexperienced. Samantha recognizes the necessity of working more collegially together with these workers on the common goal of patient care. "...like you are letting them know it is not just their work, it is our work... it is not like they have all the dirty work, you can help them too..." Where the unregulated workers are not doing hands-on patient care they are hardly even mentioned.

Sonya talks about her experiences at an institution where she had previously done a student practicum. She feels that inter-disciplinary team meetings there proceeded very democratically and collaboratively. She attributes the success to a female physician who led the meetings with 'feminine communication skills', asking questions of the other team members:

Every one would sit down in the backroom with the physicians, with the chaplain, with the physiotherapist, with every one. And we would have a meeting about each patient on the floor. Actually... nurses would speak up. Physicians would ask the nurses questions at the meetings, it was very good. But I don't know if the physician had something to do with it, she was a female physician...the male physicians would not ask everyone questions, whereas the female physician would, at that particular institution.

Bruce believes that even physicians are being pushed to become more collegial and to collaborate with others. In his setting, unlike Sonya's above, they no longer hold the exclusive

### leadership in meetings:

I think there is a working relationship in some of the things that we intersect with and interphase with the docs...where the doctor sits in rounds, in conferences, it is very equal, it is not led by the doctor any more, whereas doctors used to run them. Actually, occasionally, when she is able to, the nurse manager is the facilitator ...often times, though, I don't think nurses take the initiatives and add input.

Linda and several others perceive their relationships with physicians as unproblematic.

Linda: "The doctors are alright... I feel really satisfied with the doctors. They are winning when you talk to them about things...in the teaching hospital they are very supportive of what we are saying". Carol too is quite happy: "In my current job it is wonderful. I think there is a lot of cooperation between doctors and nurses and I think, for the most part, people have a lot of respect for each other...". Corinne does not see any major problems either. When asked if doctors respect nurses, she states: "I think some of them do, some do have a good attitude. I guess it depends also on how you approach them, it is a two-way street". Danielle too has no concerns: "Relationships with physicians? Ah, they are good I would think. Yeah, they seem to make an effort to know who is who...", she points out. As she continues she realizes that there is some room for improvement: "I find that they [doctors] are very good when we approach them or they approach us, because our documentation is an interdisciplinary care plan. But sometimes you chart and then you see down the line that the person is discharged and they are not ready. So, they do not always read our notes or consult with us".

Some of the nurses talk about having to deal with at least one doctor that is hard to get along with. Irene, who mostly works nights, says the following: "... You do see the doctors [only] if something goes not as it should. But...I have heard some stories, about some of the doctors, especially one who is so obnoxious, that the nurses just...they just try and back off when he comes...But there are others that are really nice". As an example of a good relationship, Irene recalls an incident with a plastic surgeon whom she was assisting in a procedure. He asked her permission to call her by her first name. She states that "he was not like a doctor, he was just like a colleague". When asked if he offered to be addressed by his first name too, she said "no, I continued to call him Dr. S."

Esther feels that due to the reorganizations, the relationships in her unit with physicians have improved. As they now know the nurses by name, they are seeing them as 'persons':

Before we changed over, the doctors would ask the charge nurse about all the patients. Now the nurses are more...decentralized, the nurse has quite a bit of input. Because the nurse is at the bedside, she knows more what is going on with the patients. The doctors know certain things, but the nurse knows the whole person...so the doctors should speak directly to the nurse who looks after the patient. They (doctors) treat you differently now, they listen to you. I have been on the same floor for many years and the doctors finally learned my name. So now, they see you as a person actually, instead of saying 'nurse' they call you by your name.

For her being called by name is an important symbol of respect. Shelly, who had just taken on a new job, comments on this subject: "Now in this new position... I notice who [doctor] knows my name and who does not. And the ones that give me the most grief are the ones that don't know my name... instead of saying, excuse me, can you whatever, they just basically poke you to get your attention. Which is just so rude!" On further reflection however, Shelly muses, when physicians address nurses by name it is often just a token gesture. Of the participants she alone is cognizant of the inequality symbolized by physicians calling nurses by their first name, while they themselves are addressed by their last name with the title of doctor. She feels that traditional customs, as well as gender relations in society in general, play a role in maintaining the physicians' superior status:

But, on the other hand, I don't like the fact that they know your first name, but you don't know theirs...They call you by your first name but you call them Dr. So and So. In this special unit, we are pretty well all on a first name basis, we don't get it as much here. But I bet you it happens a lot out on the floors...Some of the older ones, it is a generational thing. I don't mind calling them Dr. So and So because I know I have their respect as well. It may just be them and their perception of women in general, not just necessarily nurses in general.

She further points out how doctors rely on the nurses' guidance: "It depends on where you work and how dependent they [doctors] are on you. In the intensive care, I think we have a pretty good

relationship with certainly the residents -- we don't have interns -- but the residents rely on us very much, because basically we hold their hands through it, especially if they are young".

Ronnie describes how relationships may vary: "There are doctors who respect our judgment ...but there are those, like the chief of emergency, who is not a well liked person". She relates that, when the department received a certain amount of funding for improvement of patient care, the chief decided without consulting anyone else, not even the other physicians, to use it for a new laboratory. The autocratic manner he employed was what the staff unanimously objected to as they all had ideas about how the funding could be used. This lab turned out to be impractical, as it saved neither money nor time. Along with the lab came a strict protocol to be followed that determines which tests can be done. The staff all felt it robbed the nurses of decision making based on their professional judgement and therefore tried to retaliate: "But when he is not around, we still do what we used to do...and other doctors agree with us. It affects them as well. So, that is putting back nursing again 20 years, because we are not utilizing our knowledge for what we know now".

Samantha describes an 'uncaring attitude' of one physician she works with: "When you ask him something he is always half way out the door...". She relates a recent incident when he had discharged a patient against her objection, as she feared the patient was still too ill and needed to stay longer. Defying the discharge orders, she refused to send him home. Subsequently she was proven right: the patient needed further treatments and had to stay in hospital. Sonya describes how, on her surgical floor, it is often difficult to give good patient care as lots of time and energy is spent by nurses tracking down physicians to get orders. Of course, Sonya explains, when they have to wait, patients blame the nurses, not the physician. Sonya:

You have to phone them and then you have to wait for them to call back and you have to wait for them to come up... and sometimes they are not in the best of their moods when you ask them either... so you feel like, maybe I should not ask that question as a new nurse...I think the floor nurses, when they have gotten used to that, then they are able to ask questions. And they know, that surgeon is just like that, it is okay. They get used to it.

When asked if physicians respect nurses Sonya states the following:

For the most part I think so. I think the higher level physicians, like the surgeons, I think they expect a little more. I found that they would not yell, but they would look down a little bit more than the general physicians ...sometimes, when they ask us questions about our patients, we don't see the same side as the physicians and we don't have the answers. Then, at that time the physician gets kind of frustrated, saying, 'why didn't you do this' or, 'why don't you know'?

Diane talks about her experiences in a maternity unit where she had previously worked. When caring for patients in labour the nurses have to decide at what point to call in the doctor for the delivery. Although there are exceptions, most physicians like to minimize lost office hours or operating room time. Yet they also do not want to miss the delivery. Therefore, the nurse is left to make the crucial decision when to call them in, and his/her competency is largely judged accordingly. If the physician has to either wait or misses the delivery, the nurse gets the blame.

Diane:

You have to push with this patient for 2 hours, but in those two hours you have to decide when you need to call for a doctor whose office is at (names a certain intersection in the city) and stand there and try and figure out how long it is going to take to get from there to here. No, that is totally uncalled for. And if they have to wait 5 minutes then you are a bad nurse. And if they miss it you are a bad nurse. They are too greedy. They want to have a full office for so many patients, sitting in there waiting for them, and they want to still do the deliveries. Because there is a lot of pressure...on top of everything else...with the least sort of thing that happened they would be dictating: nurse called me at the wrong time for...I have sat there and listened to it! Put the blame on the nurse... it's terrible.

Diane muses that nurses are expected to do what no one else ever achieved -- predicting exactly when a baby will be delivered. It seems to her that the care the patients receive and their labour experience are treated as less important than the timely call to the physician. She also talks about what it is like to have an disagreement with a physician: "Having a fight with a doctor, that tends to go, like they say, a little bit goes a long way. So, when you verbalize, they are not like: 'oh she is just blowing off steam' ...Usually it gets you into more trouble...you have to be prepared to explain yourself a little bit more". When asked if she had any serious fights with doctors, she



responds:

Well.. I don't want to sound like tooting my own horn, but I can't say that has never happened to me. But I have not had a doctor not speak to me afterwards, but I have seen it...then I have seen people leave because of it. You either have the staff that stick it out through thick and thin..., or you have the staff that can't take it. And I don't mean they are not strong, they can't take abuse. And that is a lot of what it is: abuse.

Shelly points to the roots of medicine's dominance as intertwined with women's issues:

There is not a real strong female voice in medicine either....If it is not happening there, how could you expect it to be happening in nursing? So, to a great extent, nurses are still considered handmaidens to medicine... we like to think otherwise, but, you watch, you just have to watch people in action and they still kowtow to them, they still have the power.

Derek, too, feels that as far as the nurse-physician relationships are concerned, there are many echoes from the past: "I still think there is an idea out there that, if a doctor tells you something, you are supposed to do it". He talks about nurses often being scape-goated by doctors for their problems and questions the persistent influence of medicine over nurses' quality of work life: "If the staff doctor knows the nurse, and respects the nurse, your job is much easier. It should not have to come to that! As a team member, should I have to be accepted by the doctor, whether he likes me or not?...". Derek further recalls some statements made by physicians he worked with, such as "we [nurses] should do more work, we should have heavier assignments, we have far too much sick time, we have too many demands...and it always comes from a doctor". Similarly Kelly reports that "recently we had been told by some of them [physicians] to accept a 20% pay cut, instead of risking members of our profession [being laid off]. They [themselves] would not do it!"

Kelly nevertheless believes that lately physicians have become more supportive of nurses. The turmoil that resulted from bed closings eventually affected their practices as well. She thinks the change came about when they were no longer able to get their patients into the unit, "because there was not a nurse to care for these patients, then it affects their practice. Their past behaviour boils down to physicians' lack of respect. We are supposed to be martyrs or something...". She recalls that when their own interests started to be affected one of those same physicians, who

previously had publicly criticized the nurses, wrote an open letter in support of them.

## **Discussion**

Team work with other disciplines makes nurses feel as 'part of the group' and thereby promotes their own comfort. As the team members get to know each other and collaborate working relationships seem to improve and there are benefits to patients, as the approach is more coordinated. However in spite of knowing their patients' situations better than anyone else, and therefore being in the best position to speak up and represent their interests, in team meetings nurses often remain silent and align with the rest of the group. Perhaps they do not stand up for their patients as they are used to and comfortable with following orders and prefer for someone else 'to take over'. Many lack self-confidence to speak up, as we have learned. They also seem to possess a strong desire to be accepted by others and recognized as a member of the group and may not want to jeopardize good relations. O'Rourke and Barton (1981, p.16) claim that nurses have "a fear of conflict. On the most elementary level, this is expressed as the desire 'not to upset anyone'." However, it seems that this sensitivity towards others does not extend to other nurses, as discussed in the previous section. Further, in regards to unregulated workers, nurses seemingly do not perceive them as 'part of the healthcare team', despite their close working relationships. The difficulties of making decisions relying on others' assessments is described; there also seems some resentment in regards to the workers' closeness with patients, while nurses are 'managing' and coordinating the care performed by them. Thereby they themselves remain removed from direct interactions with patients.

Physicians continue to occupy a special place in the interdisciplinary team, to no one's surprise. Now as in the past, relationships with physicians despite some improvements, seem to remain problematic for nurses. Even Sonya, focusing on gender, does not question that physicians, not anyone else, always chair the sessions. To her it seems 'natural'. Several participants talk about the importance of being 'known' as an individual with an emphasis on themselves as persons, such as being addressed by name. Many physicians I worked with for years would call all nurses simply 'nurse'. It implies a code of sameness and depersonalization, which seems to continue largely today. For Irene, Esther and Shelly being called by first name

conveys a symbolic meaning of respect, with Shelly eventually recognizing that there is still an implied inequality when nurses continue to address physicians with their titles and last names. Yet that physicians should see others as equal players and value their knowledge is not something to which most participants seem to have given much thought. The 'good' unproblematic relationships that several nurses mention might be based on specific, unproblematic perceptions -- the hierarchy with physicians on top of the healthcare team remains mostly unquestioned. As the historical ties extend into the present, traditions obscure power relationships that underly the taken-for-granted.

Nurses' frequent collaboration in their submissive positions by siding with physicians against their own colleagues is discussed in the previous section. Traditional customs work in subtle ways to perpetuate the physicians' status, despite the outwardly embraced democratic organizational changes. Nursing's invisibility also keeps nurses in their supportive role in the eyes of the public. When physicians display behaviours that are arrogant and demanding it is seen as expected and inevitable and as just needing to be tolerated by several of the participants. The appropriate response seems to be that nurses adapt to their peculiarities, thereby helping to perpetuate the inegalitarian relations. When a physician is 'nice', it is often perceived as something 'pleasantly surprising' rather than the rule. A disagreement with a doctor is approached more cautiously than with anyone else, as Diane's comment shows. These statements confirm the exceptional status that continues to be granted to physicians.

Samantha's story represents an example how nurses often do important work in defiance of physicians' orders, yet their contributions remain 'invisible'. Officially only physicians can discharge and admit patients. When Samantha refused to send home the patient who needed further treatment, to the outsider it was the physician's foresight that kept the patient in hospital. The nurse's knowledge and actions remained unrecognized, while the doctor's poor judgement and uncollegial behaviour was not evident to others, hence can go on for another day. The cancelled discharge order written by the physician would be the only visible record, giving the appearance that he did his job conscientiously. The description of nurses' work in labour and delivery is another blatant example of nursing's role behind the scenes, serving physicians. Nurses' own knowledge and skills in ensuring safe labour and delivery experiences for the

families disappear and seem to take on second place, while their competencies are judged according to how well the doctors' work is facilitated with minimal interruption. Nurses tracking down physicians, acting as lightning rods when patients are upset about having to wait, once again facilitate the physician's work practices.

In addition nurses further accommodate physicians by patiently putting up with their behaviours, which are often arrogant and intimidating, as Sonya's example shows. Nurses who fail to comprehend what is expected of them, or perhaps who 'see another side', cause physicians to get frustrated and look down at them. After all, medicine's work is much more highly valued. Here too the unspoken assumption is that 'good' nurses know how to facilitate the physician's work appropriately and these expectations influence their actions. As long as they are interns and residents they depend on the nurses to teach them and help them out. When physicians become 'staff doctors', expectations of them become different from before while everyone's relationships with them seem to change. They are seen as entitled to an elevated status that is not easily questioned, a phenomenon that also has been encountered by Davies (1995) and Street (1993). Shelly expresses it well: "The staff doctors...it does not matter what you do or say, if that is their mindset you are not going to change it". Their privileged judgment remains unquestioned, as nobody dares to challenge it and the perception of the superiority of their knowledge enhances their power.

More unbridled patriarchy, maintained through bullying tactics, seems also alive and well, as when some nurses hide from certain doctors. Ronnie's story is typical, as she points out how some physicians continue to act autocratically. Yet the nurses in this situation show awareness, perhaps because previously they had experienced more autonomous practice and therefore knew of other ways. When the chief of emergency tried to take it away, his autocratic behaviour became visible to them. Being forced back into a more submissive role triggered resistance. Other examples are of physicians mixing into nursing's affairs, telling nurses to take pay-cuts or criticizing their complaints. The idea that physicians have the 'right' to tell nurses what is correct behaviour for them goes back to Nightingale and her time, as she subordinated the female occupation of nursing to the male profession of medicine within the institution of the hospital (Falk-Rafael, 1996).

Overall, the attention and approval from physicians towards nurses, seems to continue to be of importance for the latter and to hold special meaning for them. It also seems a crucial factor in regards to their quality of work life, as they continue to occupy privileged positions within the system. Despite some movements towards more egalitarian collaboration amongst the disciplines, as physicians are slowly beginning their descent from their privileged perch, for now they still retain a special status. These reports further confirm Davies' (1995), Gordon's (1998) and more recently Buresch' and Gordon's (2000) assertions that nursing, like other traditional women's jobs, supports historically 'male' professions in performing the (real) public work. Nurses remain largely invisible and behind the scenes, thereby making it possible for physicians to do their own well-defined, specialized work, for which they get societal recognition. Thereby physicians keep up the appearance of 'professional autonomy', while nurses fill in the gaps and cracks for them and make their performances run smoothly.

Traditionally another group nurses work with also tells them what to do and impacts heavily on their practice. In the previous chapter we learned that nurses perceive control over nursing issues to be increasingly shifted toward a business approach. They also felt degraded by administrative representatives in how they were treated at times. Therefore the nurses' relationships with administration will be examined next.

## **Relationships with Administration**

### **Participants' perspectives**

They [administration] don't come to the floor, I mean they come once in a blue moon....I mean there is communication in some sort of a formal kind of realm, but for them to come and sit around and say sort of 'what is the problem in nursing'? You know, they don't do that. (Danielle)

We never get good news... no management person comes and says, you did a great job! It is always we have to cut back from here, we have to stop that... sometimes it is not even giving people what they want but listening to people and treating them with respect. (Derek)

In the previous chapter I describe the participants' impressions that control in nursing

affairs has shifted towards a 'business approach'. However, who are the people behind it, especially in higher administration, seems a mystery, as they remain faceless and nameless. Like Street (1993) I find that the staff nurses I interview are mostly unaware of who the people are in charge of their institution. Sometimes, if little else, at least their names are known from memos, the medium of formal top-down communication. Most of the time they are simply referred to as 'they'. In regards to what their actual role is, the participants seem unsure. 'They' seem as distant (and arbitrary) as the gods of the Olympus were for the ancient Greeks. Their anonymity is preventing formation of relationships with them. Who the nurses know and interact with are the people in middle management, the unit managers. Therefore most of their comments are about their relationships with them.

The invisibility of administration is explained by Irene. About the people in higher administration, she states: "...it is hard, you don't see these people, you just hear about them. So, if you have a problem, where do you go to? 'They' must be in an office somewhere...". When asked if she thinks they respect nurses, she responds with optimism that they would, if they only knew what role nurses are actually playing in health care:

Mmmm, for the most part I think they do, but I don't think they understand fully what nurses go through...and I think if they knew what you sacrifice sometimes to do the job, the personal and everything else, I think they would have more respect ... because actually it is the nurses that let the physicians know. ...it is the nurses that are by the bedside. They are the ones ...that know everything that is going on.

Danielle talks about a nurse-administrator at her institution who had held a senior position. She had taken seemingly revolutionary steps wanting to involve the nurses on the frontlines in decisions about changes. But, Danielle reports, she quickly 'got walked out the door':

...that is the problem, that we don't really know them...like the previous nurse administrator, I saw her a couple of times...Her philosophy seemed to be very decentralized, she felt that the decision making should be done at the point of impact, like at the frontline...because she said that was not her specialty even though she was a nurse....Now they have another gentleman running things and that and really -- you know he really is out of it.

Derek points to administration as responsible for the state of the healthcare system: “Administration is just gone from bad to worse...the old boys system seems to run everything in this province and I don’t think these are positions you earn... I don’t think it is run democratically”. He describes wasteful practices, such as changing the name of his institution repeatedly in the last few years. This means every time discarding letterheads, logos, anything that bears the old name. Then there is the constant turnover of nurses: “Again, I blame it on management. If there were structured orientation programs and better educational support, that would not happen”. Derek also complains about lack of caring and recognition from management towards nurses. As ‘they’ seem to make unrealistic demands, ‘they’ always find something to hold against him:

I am getting harassed that two weeks ago I was off with some stomach cramps, maybe from something I caught at work...if I am sick one day, don’t harass me about it. You want a doctor’s note, I am more than prepared to bring one. Anyway...a lot of negative things have to happen. It is always...well, there is never any praise, but there is always a lot of influx of negative things, and new expectations from the hospital, despite that you are not able to meet the expectations they have now, because they are not realistic.

Who the nurses most of the time deal with directly are their unit managers. Carol, trying to understand what goes on, talks about the complex situations that she believes the unit managers find themselves in, sandwiched between staff and higher administration:

...with administration, I think there is a lot of push-pull situations in dealing with administration. The ones I deal with are mostly middle management. It is your head nurse, or your charge nurse or your nurse manager. They are not only trying to please you, they are trying to please the upper echelon. And they hear about it from up top and they hear it from down below. And they are kind of stuck in the middle and are not sure which way to go...it helped me to realize that there are other issues involved and that there are other points that need to be brought in... I have always tried to see the other point, but I have also tried to make sure that my point gets heard.

Anna also recognizes the difficult positions of nurse managers and that they may not be free to act as they necessarily would like when orders come from above. As a case in point she talks about the introduction of unskilled workers:

The managers have to find support among their own managers, due to the difficult position they had been put into, as they had to introduce unskilled workers. There was no choice: deskilling or job loss. I don't think they agreed with what happened. Was it done to further divide nursing? Maybe. It was not supported by nursing, it created a division in nursing. It has not helped the environment or the patients.

Linda, who works permanent nights and holds part-time positions in two different hospitals, makes a comparison between the styles of her two managers: "In my chronic continuing care we have an excellent unit manager; she is very, very supportive, she is involved in education and we always have in-services on the unit to upgrade you. And she is in touch with her voice mail and she is always talking to us through the voice mail, [even though] she does not see us". In her other job, a coordinating nurse deals with the day to day affairs: "The coordinating nurse was one of us a couple of years back. But somehow she has lost touch...what nursing is all about. And it is very hard. When you go to her with a problem, she will tell you 'I am not doing anything about it, because I don't deal with it'... there are administrators and administrators".

Even when they have supportive managers who welcome them to be involved, not all opportunities for improving their working conditions are always taken advantage of by the nurses. Sarah relates how on her unit, in the past, the manager had allowed the nurses to assign their own breaks. It was hoped that in this way they could be fitted most appropriately into their work day. "We tried to negotiate breaks so that we have an equal number of nurses to cover. And it turned out that people like to go with their buddies and there is that silliness. Meanwhile there is not enough coverage. And the ways in which we were working on that is to negotiate. And some people are great at negotiating, but there are others... we had to go back to assigned breaks...". She feels these nurses showed a lack of 'responsible judgement', as they preferred to cultivate their personal relationships with co-workers without giving the appropriate consideration to patients' and colleagues' needs. Perhaps, she thinks, they are simply used to being 'told what to do' by others and not to making their own decisions.

While in the above situation Sarah feels it was justified to go back to assigned breaks, control was reclaimed even where nurses acted responsibly. Danielle reports how, after a time of self-scheduling, management took back this function. On her unit the nurses had been in the past



“pretty much self-running”, in regards to their work times. Now, with a different unit manager, they had to go back to assigned shifts. In this particular unit, before, “more or less, the charge nurse was quite flexible..., with shifts for people with families, you need to sometimes juggle things around a bit, and I don’t think people would ever leave the floor unstaffed or unsafely staffed....and so this [function] was totally taken over by ...an administrative assistant, and there is not much flexibility...”. The same happened in Carol’s unit where nurses also had been self scheduling. She too questions why work assignments are now the responsibility of an administrative assistant, seemingly without regard for nurses as individuals who have families and other responsibilities. She also points out the importance of solidarity amongst nurses to bring about desired changes:

She [clerk] forgets that we are humans first and nurses second...it is about having the experience of being a nurse and having to fit your life around shift work. So that you are working to live, not living to work....there seems to be a big block with self scheduling, so that people have more control over their schedules... when you are low on the totem pole and your seniority for vacation is squat, and you are looking to try and get some time off for your family get togethers and stuff, the reality is that it is a fight, a constant fight!.. the only thing I see changing that is the self scheduling routine. But then it goes back to communication and the realization that there has to be cooperation. And it has to come from everybody. And places where there is that lack of support, that is where you run into trouble.

Irene believes that her manager either does not want to listen or does not value her attempts to further her education. She relates how she had indicated her willingness to work any night of the week, except one: “...all I ask is don’t book me Sunday night, so I can go to school Monday morning...I have written to her, I have talked to her on the phone, I have talked to her in person. And the new schedule came out and she had me down to work every Sunday night”. As Irene is usually unsuccessful in finding someone who is willing to switch shifts, she is forced to make decisions between caring for herself and fulfilling her obligations: “...and I end up going to school after being up all night either that or... once I called in sick, and I wasn’t. But I felt bad, but I am making myself really, really sick to stay up and go to school. I can’t do this”. She concludes in frustration: “when you try to be fair you get nowhere”.

Ronnie relates how she felt offended when her manager, on several occasions, brought around official visitors from other hospitals to tour the unit. Yet he never introduced the nurses to any of them. One day she confronted him:

[later] I met him in the coffee room...And I said, 'I was waiting for you to introduce me'. So he said, 'you were so busy'. [I replied:] 'you saw me with a patient, I stopped when you guys came around, because I did not want to...ask confidential questions of the patient in front of you guys. But you never introduced me, you just walked right past me'... he did not say anything, you know those are small things, but day to day things. If they could only be more attentive to that, it would make such a big difference.

She goes on discussing the importance of support and particularly respect for nurses by management:

But in this particular department we don't get that [respect], not just me... And we all voice that as a frustration. And because of this particular problem, personality issue, or nature, I don't know if I should say that, elitist is the only thing that is appropriate... One time we lost the narcotics key, we kept losing it from one area of the department. Management all of a sudden decided, no, we are not going to have narcotics there any more. Treating us like kids, you know, we kept losing the key... So people from this area have to go all the way to the other area, as a punishment...So, that was one of my complaints. Eventually they replaced the narcotics...in the coffee room I heard my co-workers say over and over: 'Treat us like kids, that is how we are going to behave'.

She relates that in the past nine months they have lost seventeen staff. "And a lot of them have said it is because of management, not because of the department". In this situation, the nurses were asking for a staff meeting, "where people are allowed to vent their frustrations", but the manager kept putting it off. Ronnie thinks it is because he does not want "to face the crowd. We have some strong personality nurses in our department who can just stand up and speak up to the chief of emergency doctor too...and he knows his time will come, when the time is right...". Derek, too, talks about lack of respect towards nurses and being treated like children by management:

And we are treated badly! Like kids, that are screamed at...threatened and until this day it still shocks me. I am not always super friendly, but I always respect people and try and treat them well...And that is all I expect back.. And also the way management treats nurses... shocks me, shocks me!...nurses...unfortunately they put up with so much garbage. They are demoralized, given no support, when something is wrong in the hospital, guaranteed it comes always back to nursing.

Diane points out that a good manager has to be familiar with nurses' work: "In my department our manager tries to understand where we are coming from". She explains how, in the past few months, he had come in four times on the night shift, to help out. As a former staff nurse, he seems to understand their difficulties. Irene, who has the problem with scheduling to attend her classes described above, attributes the unsupportiveness of her manager to the fact that she is not a nurse: "She is a social worker, not a nurse, and she does not have a clue what shift work is like. She is gone every night, she has every weekend off, I mean every holiday off...I seem to be working every holiday going". Sonya, too, relates her experience on this issue:

The manager was not a nurse. I don't know what he was...and he was managing the nurses...and he was actually in charge of reviewing the learning plans for the nurses...for quality assurance in terms of the patients/ clients. He had to make sure that our quality of care, our service was good. But he had nothing to do with nursing. I don't think he had a very good perspective in terms of nurses and what they did, so it had been very hard on the nurses on the floor.

Carol expresses frustration about why non-nurses are the health services leaders of hospital floors and in charge of nurses. "And why, when the health service leaders are dealing 90% with nurses, why are they not nurses?" Derek too wishes that nurses would be more involved running the hospital versus a "number man", cited previously. Danielle sums up what seems by now familiar. There is "just a general lack of respect for... and inclusion of nurses into the decision making".

## **Discussion**

The main perception of the nurses is that administration is run by people they do not know and who they assume know little about them and their work. In the one example about a higher administrator who tried to have a closer relationship with staff, listening to them and

involving them in decision making, it seems that it was a serious faux pas. She got replaced quickly with someone who, according to Danielle, seems 'out of it' and uninvolved. As distant management represents the unknown in the system, unit managers seem to be the most important flesh and blood people who can make or break a work place. They are the link between nurses and higher administration and seem to hold a pivotal position with the potential to mediate for better conditions for nurses. If they understand and value nursing they can make an important contribution by making it visible to those in higher administration. Where they are perceived to be supportive of staff and knowledgeable about nursing at the bed side, such as Diane's current unit manager, everyone seems to be happier. Ronnie's and Derek's stories, on the other hand, illustrate how they are treated with a lack of respect. Their experiences and thoughts on them are very typical of relationship struggles between unit managers and nurses, with similar issues reported by others.

The greatest dissatisfaction is encountered in those situations when the unit manager is from a different discipline. The nurses in this study feel that outsiders do not know about the nature of nursing jobs, especially during shift work, compounding their lack of respect. In hospitals nurses are the only ones present 24 hours a day, over the course of eight or twelve hour shifts. Other services, from which the managers are increasingly pulled, are provided during the day and perhaps during evening shift on a reduced basis, such as social work and physio-therapy. None of these disciplines works the night shift. They all treat aspects of patients, and none of them is involved with the whole person and all their needs, as nursing is. Add to this the difficulty of delineating nursing work, which does not have clear boundaries and is largely invisible to the outsider, and it becomes very hard for others to understand what nurses do. Davies (1995) discusses this phenomenon of non-nursing managers that also exists in the British system, as an example of 'managerial science' slowly replacing 'discipline specific' knowledge as the privileged form. Solutions to the 'health care crisis' are thought to be brought about through better management, by strictly looking at 'outcomes'. Therefore, in theory, the background of a manager is believed to bear no importance on his/her generic ability to 'manage'. Privileging this type of knowledge can easily lead to the 'bottom line' overriding 'quality of care'.

Despite the loudly and publicly professed emphasis on education by institutions, in reality there seems little support for it. Many in-service and orientation programs have been cut back as a cost-saving measure. Even when nurses pay for their own education, they encounter nothing but barriers at the local level, as Irene's example, about being scheduled the night before her Monday morning class, vividly demonstrates. Many others also complain about how difficult it is getting the time off to go to school.

Leaving as a type of resistance is a typical strategy that nurses employed historically. Yet, other patterns of resistance are also emerging in places, probably because it was difficult for a while to find a job. As no one was hiring, many nurses were forced to stay and deal with the situation. In Ronnie's example resistance in the form of confronting the unit manager is emerging at the local level. Hilda too has some advice as alternative to running away: "I find if you speak up and give your side of the story, and you are not afraid to stand up for yourself, you practically have to stand up for yourself, and I certainly saw it more than once, and I find that the more you do it, the more they respect you...". In Ronnie's example the nurses are beginning to challenge their manager's authority, by asking to meet with him over these issues. There seems to be an emerging realization of nurses' own strengths inciting their united resistance. Perhaps it is recognized by the manager too, inducing him to stall.

However, it needs to be said, that nurses do not always grasp opportunities that are offered to improve their conditions, as we have seen in Sarah's example. When the nurses had the freedom to determine their own breaks, they did so for their own personal reasons with little regard for the needs of others. As power relationships are always complex and articulating with many neighbouring discourses there is no guarantee that desired outcomes will automatically follow the opportunities. It goes back to nurses being humans, constituting themselves with conflicting desires, wants and needs, and shaped through training and work practices to listen to others that tell them what to do, or to resist passively rather than openly.

Overall there are few positive examples of relationships between the participants and management, even at the unit level. A perceived general disregard for nurses as individuals -- a lack of respect -- is the most universal complaint, followed by decisions being made by people who lack knowledge of the bed side without the nurses' input.

### Summary

In this chapter I try to show how power works through the strategic games of the various players. It is not a simple matter of either possessing or lacking power; power and resistance are exercised by all in many places and by many means, building on and expanding other existing relationships. Power's productive effects are not monolithic but heterogeneous as they appear at the local levels in many forms and guises. New insights were gained, I believe, by looking at power from below at the practice level instead of through the usual top down institutional analysis. In instances where the power relations were not specifically recognized as they were taken-for-granted, no resistance was noted. Examples are nurses facilitating the physicians' autonomy and reinforcing their superior status through unquestioned acceptance of or accommodation to their authority.

The nurse-patient relationship generally remains the heart and soul of nursing, despite the strains that restructuring imposed. I will try to uncover further some of its much more subtle power relations in the next chapter in which nurses' subjectivities are explored. The data of nurses' relationships with each other show that power works insidiously and simultaneously through varied mechanisms. Their comments and stories reveal power's embeddedness in the social networks, the systems of differentiation expressed as many hierarchical relationships. Unquestioned codes and traditions perpetuate these mechanisms of power, often unbeknownst to the players themselves. Examples are who can call whom by first name, who is addressed with titles and last name, who can write orders, who has to carry them out, whose knowledge counts, whose is discounted and invisible -- how 'the actions of the various players act on the actions of others, actual and potential'. These deeply embedded hierarchies according to perceptions of status and whose 'knowledge' is more valuable shape and distinguish relationships -- within nursing's own ranks, amongst the health disciplines, especially doctors and nurses, as well as administration and nursing. They impact on the positions of players amongst each other, making them appear naturalized, and are 'simultaneously their origins and their effects' (Foucault, 1982). Nurses' historical roles, as handmaidens who follow orders, continue to influence their positions vis a vis other groups. Caught up in these long-established webs, nurses often are vying for approval by groups that are perceived as more powerful. They therefore continue to look for

support and approval outside of the discipline rather than from each other.

There are many mentions of 'lack of respect' for nurses and failure to treat them as individuals. Physicians continue to hold a privileged position in the team. Nurses still play their supportive and mediating roles, making excuses for them, preventing and rectifying their mistakes. As they smooth the way and fill in the gaps, they continue to facilitate physicians' work, helping them to keep their elevated societal status and to make their practices appear autonomous. Yet these customs leave the nurses themselves standing in the shadows without official recognition. Administrative power seems to work mainly through its mystifying invisibility. The presence of unit managers at the front lines deflects attention and anger away from the main decision makers, who remain unknown. The dominant managerial discourse is impacting work at the local level, often building on existing practices such as uncollegiality and exploiting them by designing work patterns such as casual staffing. Several nurses recognize a return to tighter control, after there had been some decentralization, such as input in their own scheduling; other participants believe that administration is truly uninformed about nurses' work and what happens at the bedside. In the study of British nurses' job satisfaction by Tovey and Adams (1999), poor relationships with management were also cited as a major cause of nurses' discontent in some institutions. However, many of their nurses, too, failed to make a connection between working conditions and management.

The instability of power relationships is noted here and there. Nurses' involvement with the multi-disciplinary team is improving communication between them and the other players. Yet, the danger is that, by trying hard to fit in, they often miss the chance to develop their unique roles and contributions as representatives of their patients. They seem to be going along with the team even when it is against the interest of their patients, following traditional patterns of letting someone else take over, reinforced perhaps by their own insecurities. On the other hand, there are also new signs of resistance. After losing their previous fairly comfortable and safe positions, nurses are beginning to become more aware that there is strength in numbers, as the many job-actions in recent years have shown. In an above example we see some open challenge of an unit manager who fails to show respect to his staff. Here and there support for each other begins to emerge at the unit level, with good success. There are examples of individual nurses defying

doctors' orders when they believe their patients' well-being endangered or their own knowledge base discounted. However, these acts remain hidden within / through the existing official documentation. There are also emerging stories of more open communication with other colleagues over unfairness in work assignments or other disagreements.

Nurses' relationships with others are structured, consciously and unconsciously, through their own and others' perceptions of nursing within the context of their interactions with the interdisciplinary team and their patients. To learn more about these processes it seems important to explore their self perceptions and self-styling practices. The next chapter will therefore deal with nurses' subjectivities. We have learned how nurses' roles in the restructured system are leaning towards managing others, versus hands-on care valued by nurses themselves. There are also the old, often unquestioned images of the handmaiden and self-sacrificing angel that still seem to impact on nurses' own and others' perceptions of nursing. In the previous chapter discomfort amongst other disciplines is noted, as they perceive themselves of lower status, mainly due to the lack of a university-based education. Within these discourses they often fail to recognize their own important contributions to healthcare. How the nurses wish to practice -- their relationships with themselves as 'socially desirable nurses' -- will be explored. I am attempting to shed light on how the various discourses get negotiated within the participants' own consciousness, to produce their images of nursing now and in the future.



## **CHAPTER 7**

### **SUBJECTIVITIES: SUBJECTION AND SELF FORMATION**

#### **Introduction**

In this chapter I explore the participants' views of themselves as nurses and their ideals of nursing -- how they would like to be perceived and practice. Thereby I hope to learn more about how they take part in constructing their subjectivities, the processes through which individuals are turned into subjects. Foucault (1982) believed that, knowingly at times but mostly unknowingly, individuals adopt societal concerns and attitudes and feel tied to them by their conscience. Prior to deliberately choosing their values many complex mechanisms take place that act on people's 'bodies, souls, thoughts and conduct'. In these processes of 'subjectification' (Rabinow, 1984), self understanding is usually mediated by an outside authority, such as regulatory and institutional bodies of a discipline, or through chosen role models. As these processes are never transparent, not even to the individuals themselves, it is only within the range of their awareness that they are able to 'choose' and 'reject' how they want / do not want to be. Their choices are restricted to and impacted on by the 'field of possibilities' accessible to them at their specific time and place, hence can always change. Through these complex mechanisms they develop images of themselves as 'moral' subjects and fit themselves out with the 'desired truths'.

In the first part of this chapter the participants talk about their personal perceptions of nursing, when they first started and now. They specifically elaborate on their disappointments in nursing. They are invited to discuss the philosophies which guide their practice, including patient-focused care where applicable, as it is the philosophy adopted in one institution. Lastly they talk about their images of the 'ideal nurses' they envision. Through their reflections I hope to learn about how the 'socially desirable nurse' is constructed and what conditions they believe to be necessary to make excellent practice possible. Using Foucault's ideas, my previous chapters on nursing's history showed that its discourses, like those of all societal institutions, are shaped by 'scientific categorizations' and 'dividing practices' accepted as true at the time. They are also contingent on, and embedded in, all the other 'neighbouring practices' such as the restructuring processes, which in turn are connected to the political and economic discourses and events, and

with them undergo simultaneous ongoing modifications. As nursing remains overwhelmingly a 'feminine discipline' and, as history reveals, nursing's image is closely tied to the discourses about women.

In addition there are the personal experiences and visions that lend variations to each nurse's ideas about nursing and the characteristics and conduct of a 'good nurse' they deem to be acceptable / unacceptable amidst the changing larger societal views. These ideas represent the aspects of 'active self formation', usually arising from awareness that they are experiencing 'exploitation', 'domination', or 'subjection' -- how they 'do not want to be' (Foucault, 1982). In the previous chapters we see that resistance is expressed during conflicts between their ideals of practice and institutional demands imposed on them, such as heavy workloads and non-nursing duties resulting in lack of time to interact with patients and to provide good care. It also arises over perceived devaluation of their knowledge and contributions, and lack of compensation and respect for them, which perhaps are not new phenomena but have become exacerbated in the current climate, as there are fewer intrinsic rewards.

Later in the chapter the nurses' ideas about the occupation of nursing as a collective discipline are examined, i.e. where they think nursing should go from here and how they want to get there. Views on proletarianization, such as job actions, as well as professionalization, including thoughts regarding education, are also examined. Perspectives on the degree requirement as entry-to-practice are explored. The personal image of nursing and the collective view of the occupation are different facets of nurses' subjectivities and increasingly melding together as Farrell (2000) maintains. Both contribute to nursing identities. One calls for discipline as 'self government', the other for collective and political endeavours in which nurses participate together. In the past and the present personal improvement is foregrounded, as nurses are constantly encouraged by their leaders to enhance their practice through education, better time management, cooperation with the interdisciplinary team, reflective practice etc. Yet, as the previous chapters show, mutual support and being together is slowly recognized as an essential strategy of resistance to bring about desired changes. Why nurses choose nursing, their philosophies and ideals of practice as well as their disappointments are now explored.

## The Choice of Nursing

### Participants' perspectives

I grew up in a Roman Catholic home and went to a Catholic school that was run by nuns. And the nuns were also nurses. So it was my dream to become a nurse...all those years. (Linda)

I don't know...for some reason, right during high school is when I made the decision to go into nursing... I can't think of one particular thing that influenced my decision to go into nursing, but there were a lot of things that happened afterwards to support that decision. (Carol)

The above comments were quite typical as to why these nurses went into nursing. Some seemed to slide almost naturally into it. Others first weighed their choices more or less carefully. Several, like Carol, gravitated into nursing without thinking much about it. Once in nursing and liking it, Carol, like some of the others, had academic obstacles to overcome:

And the reality of nursing kind of hit by the end of first year. I didn't know all this was nursing, they never do that on TV... I failed tests and rewrites and got booted out of the course! Being a student never has been a great love of mine in the early years, I enjoy it much more now, than I ever did. That downfall in itself didn't...it only fuelled my desire to become a nurse. It strengthened my desire more so than anything. It was something... dammit, I am going to do this now, if it is the last thing I do!

Danielle represents another example of someone who did not really deliberate beforehand or, if she did, does not remember much:

Well, I don't know actually... I probably just wanted to be helpful...in a helpful kind of profession. I have done candy-stripping when I was a teenager, and I guess hospitals did not make me sick, so I figured I might apply for it. I must say, I did not really think of much else, so I decided that was it, and went into it and never thought much.

Samantha seemingly fulfilled an early dream by becoming a nurse. She too had never considered doing anything else. 'Taking care of others' was a strong desire for her:

Actually I decided when I was around 5...when I was little, I remember my aunt used to be a nurse. I used to always look at her and my neighbour who was a nurse and think that I wanted to be one too. And if someone cut their hand, I used to always run and watch and things with all my girlfriends... Ever since I was a little girl I wanted to be a nurse. I never changed my mind. Even when I was little, I used to always take care of my brother when he was sick, or my sister, I used to like that. Like if they wanted something I used to get them food or something. And then, in high school, I could not go into nursing, my marks were not good enough. I just never tried... so I did not get in. So, because of my marks I had to take that pre-health program and it gets you into nursing. I really stuck with it, because I always wanted to be one...I thought of it as, you are a caring person, you take care of people and all that stuff.

Role models were an influence on her and several other participants' choices. She also was one of several who had to upgrade their marks to get into nursing school.

Esther's perception of nursing as a 'natural' job for women is typical as well. It shows, once again, how nursing is closely associated with discourses on women's roles:

I think I always wanted to take care of people. In my family I was always placed in that position, where I had to take care of the rest of my siblings. And of course at home, where I came from, as soon as you are able to do housework, to cook, to clean, you are left to do this. So, I was always in that position, where I was taking care of other people. I think that was one thing that put me in nursing.

Of all the participants Irene had to scale the most difficult hurdles in the pursuit of her life-long dream. She was middle-aged when she finally realized it. "I always wanted to be a nurse, ever since I was a little girl...I remember on Christmas we had sent a letter up the chimney to Santa Claus and I always asked for a nursing uniform. I would take care of all my teddy bears. My grand father was a nurse, all my cousins in Scotland are male nurses, it's funny...yeah, I was the first female in the family". She talks about hardships she encountered. Growing up she had taken care of her siblings due to family problems. Then she got married and had children. "So, there was never the right time, there was always something else coming up. I had to work, so I became a secretary. That is what every one did in those days. I was good at it, but it was not what I wanted". One day, however, she read a story in the paper:

It said that this woman was getting celebrated because it was her 100th birthday. She said she had a marvellous life, except she always wanted to be a nurse. And in those days her Dad did not let her become one. And it just hit me! I was in my late thirties, and I said... I am getting there. I did not want to be like that poor lady. Because you could always say, all your life that there is never a good time. And there will never be a time where you can actually sit down with a calendar and pick a good time. If I wanted it bad enough, I have to sacrifice now. So... I left my job, which really almost cost me my marriage. My husband... I got myself through nursing school, he could not support me, he was so mad at me for giving up my job, because it was hard for him... we just fought constantly while I was in nursing school, about how I had chosen dreams and I could put the whole family into the street.

Because of her personal difficulties she took the part-time program. It ran in the evenings and lasted the whole summer! "But at least I was home during the day time. Just to get money to buy groceries and stuff I baby-sat a little boy and tried to study while he slept. It was a hard time, and so it never actually stopped being hard, it just keeps getting harder and harder... now working nights and going to school...".

Corinne is the only participant who openly expresses her disillusionment with the career of her early dreams. She wishes she had further explored it before acting on her childhood aspirations. Her parents had advised her

...to go into engineering or something. To be honest with you, I wished my parents would have had a little more influence, with what I wanted to do career wise. I thought a nurse would be in the nursing profession. I never looked into the salary, I never looked at anything else. I just thought the word, you know, when you are young, I thought of the word nurse and I thought wow! I become a nurse, it is ideal. My aunt is a nurse, I never really confided in her, I mean she is in Australia, I never asked whether it would be a good profession.

Yet there are also those for whom it is a more carefully weighed choice. Linda, cited at the beginning of this section, decided early on nursing. She had grown up in a different part of the world where she first became a teacher. Several years later, after coming to Canada, she finally went into nursing. She further describes her childhood impressions about Catholic nuns who were nurses and ran an independent nursing station in an African country. These 'role models' became pivotal later on to her second choice of occupation:

As I say, watching those nuns with their hooded things...we would only see their little faces...it really used to impress me, the kind of things they would do to all of their cases, because when you were sick you came out from the clinic, walking. Because they gave you a needle or something, whatever they used to give us, it was great. And you wanted to know if you could give, whatever they were giving. And that is what really has driven me into nursing, and I have been doing it ever since.

Many participants first discussed career choices with parents and counsellors or underwent ability testing. Kelly recalls: "We did all these tests in school and I scored always high on mental social things... I always felt that nursing had a lot of flexibility, you could do bedside, teaching, ICU (Intensive Care Unit)...and it was also flexible with a family, you could do it part-time". Shelly feels she got more or less 'channeled' into it. Nursing was not thought of by her teachers as a discipline that was high on the social or achievement scale. She suspects that her social status was perceived as limiting her possibilities for advancement in life.

Way back when? You know I really don't know for sure... Even when I was working and I was 14, I always had a job, where I was working with the public in some sort or whatever. I know, at one point, I considered medicine, but really did not have the financial means to be doing that, and I don't think I had the confidence to go through with it at that point. I was not a good student in high school and I was told I would not do much of anything. I mean there was a lot of prejudice, because I came from a pretty poor background and...the poor students of course will never go to university, because they are stupid.

Shelly went into teaching after becoming a nurse and switches back and forth between the two occupations. Right now she is holding both jobs part-time. She relates that, angry at being cast into the 'poor student' category by her teachers, she proved them otherwise and got top marks in her academic endeavours, which she too found harder than expected.

Jennifer in her usual humorous manner talks about the limited choices open to women in her time. Nursing was not a realization of dreams, but a practical decision:

Well, it goes like this. The idea of getting dressed up, putting on high heels and prancing off to an office to sit on a boss's lap and take notes and work on a type writer, never appealed to me. I did not want to be a teacher, because I could not

stand the idea of 30 sets of eyes boring holes into me, I did not like school. And I could not figure out what else to do. At that time women were not as adventurous and they did not drive tractors and do all the things that they do nowadays and I would have loved to do... so I thought, well I can go into nursing. I have got a fairly strong stomach and so, and you know I was sort of fairly good in helping people and it is not an office job. I don't have to dress, I can wear a uniform, it will be alright. And here I am.

Hilda, citing some of the same reasons, wanted to do something where there was “action on the job”. After grade 13 she was “tired of sitting on a desk”. And Sonya completed two years of an university arts program, got married and had two children. After staying home for 3 ½ years she was pragmatic in her choice of nursing:

I always liked helping people. I thought of nursing, that would be the most viable thing I could do, the most feasible thing, as a mother going back to school. When I went into nursing I thought it was just bedside nursing. But now there is public health, community nursing, you can work in a daycare, working at a school, working in a hospital. You can work in people's homes, with children, elderly, there is just so many different things, so many different areas. And in that way it is much more exciting.

Ronnie saw nursing as a means to an end. As a child she had witnessed a nurse doing missionary work, who then became her role model. Therefore her ultimate goal for becoming a nurse was to do missionary work. After nursing for ten years, a few months before the interview, she had travelled with a multi-disciplinary health team to a developing country. She recalls excitedly the primitive conditions, the dirt, yet: “It was wonderful. To me that is nursing! So, finally I did it! That was the reason why I went into nursing, and if an opportunity arises, I still will want to go to different places and having that as part of my life, it will transform me in a way”.

Bruce, who has ‘lots of doctors and nurses in his family’, made his decision after careful deliberations:

I wanted to take medicine, but I saw that nurses had more time with people than doctors do and that is why I think...and also my mother looked at nursing as far...probably as a caring profession. And through my own experiences with

nurses and doctors I aligned myself more with the nurse...that is what drove me....I wanted to be a neuro-surgical nurse, I wanted to be able to do those things...to do the technology. That is what brought me in.

As far as the other two men are concerned, Derek chose nursing on second thought, sounding a bit self conscious about wanting to 'help people':

I was in a job that I hated, I was a buyer. I had to travel too much and did not like the job at all. I had a horrible boss and I was not sure where I wanted to go. I had some friends that were nurses... on the whole they really liked what they did, they seemed to get some satisfaction from their job. And, it sounds corny to say, I do like to help people. But certainly that is part of it, I don't know if that is the main one. I knew that there would always be jobs, I knew it would be flexible. I knew the salary was not amazing, but it was okay...it is also a profession where you can sort of reinvent yourself. There are so many different aspects in nursing that you don't ever really have to get stale, so you can do so many different things, I think that is the biggest thing.

Jack tells an interesting story. He had decided, at this point in his life, to get out of the various jobs he had been working in and entered nursing more or less by default:

I got into nursing by accident. It was not even planned. I had a lot of different jobs over the years, before getting into nursing, working in construction, I did some pretty crappy, terrible jobs. It gave me an appreciation for not wanting to do those jobs any more. And so I was looking into something else. So I tried to get into dental hygiene. On the day of the testing process, to see if I was a candidate for the program, I had a really bad attack of renal colic. I missed it and the only thing open for me still was nursing. I did not really ever think of nursing and certainly not me in nursing. So I put my name in and they accepted me. And...it was an eye opening experience, it was a really tough program. We worked like Trojans. And out of our class of 300 probably less than 100 graduated. But standards were really high, the expectations were really high.

Once in, like all the others he was quite impressed with the challenges that the occupation poses. Kathy is thoughtful and serious as she talks about unexpected benefits she found in this career path: "There is one thing about nursing, it was really humbling... it has really changed me".



## Discussion

For a long time in history nursing was seen as an occupation that was 'natural' for women and that good nurses were 'born, not made'. These beliefs point to expectations about certain characteristics of the type of person that chooses this kind of work. Participants for whom nursing was a life-long dream, come closest to the common stereotype of the 'self-sacrificing angel', as their choices seem based mostly in emotions. Several of the women chose nursing as a job appropriate for females, as there remains an underlying theme of nursing being 'the natural thing to do' for them. However, this reason is mentioned more likely by the older female nurses - - Corinne is an exception -- and seems to have featured more in the past than today. Others carefully deliberated, including those who entered it as a second career. Two of the men and some of the women fall into this group, while a few came back to it, after holding other jobs for a while. Even Jack, who claimed he got in 'by accident' had known before that he wanted out of the 'horrible jobs' he worked in and looked into health related occupations.

Several participants, including some of the 'dreamers' had to work hard to achieve success, as it was not as 'easy' as they had thought. Yet they doggedly persisted in bringing up their grades through remedial classes or repeating courses. This seemingly widely held assumption about nursing as 'easy' is also reflected in Shelly's account of her teachers' beliefs that it was achievable for her, a member of a 'lower socio-economic class' with 'limited potentials'. Irene's story in particular illustrates how the desire to become a nurse seemed to grow stronger in face of all the adversities she continues to experience, even now, as she is trying to obtain her degree through part-time studies, while working. As mentioned, she had been a secretary before going into nursing. Two other female participants had taught English as second language courses, two are previous school teachers and one of them continues to teach part-time in a Community College, while also working as a nurse. There are many similarities between these three traditional 'female' occupations. Historically they represented 'fitting' career choices open to women. All are ill-defined and non-specialized; all involve caring for others (Acker, 1999a;b; Davies, 1995; Mills, 1956; Witz, 1992).

Once in nursing, all participants liked the satisfaction that comes with this type of work and all agree that nursing is, or at least could be, a worth while job. They welcome the flexibility

and variety of opportunities it offers. They talk about 'the chance for personal renewal' and 'transformation', which indicates conscious self-styling -- as Derek put it, where you can 'reinvent yourself'. Similar descriptions of conscious 'self-formation' are also evident in Kathy's and Ronnie's statements and those of several participants who entered nursing as a second career, or came back to it after working elsewhere. 'Helping people' is what all participants have in common and enjoy. This realization came to them at some point in their careers, frequently after they entered nursing, if not always before. They are 'humbled', impressed, surprised about what nursing entails, including that it is much harder than they had anticipated. Yet there are also disappointments, particularly today, which will be examined next. Some of them are further confirmations and expansions of what is discussed in the previous chapters.

## **Disappointments**

### **Participants' perspectives**

When I was little, I thought nursing was, you take care of somebody who is sick, and now you are going to end up having a healthcare aid looking after them. I guess it is also because of restructuring and cutbacks too, ...more responsibilities, you are looking more medically at the person, in a way...and I don't know if that is really nursing any more.... because on our unit in the hospital, the nurse does already the serious stuff like IVs and that... and the health care aid is the one who will wash the person and put lotion on their back and keep them company and feed them, you know what I mean? So they end up getting closer with the health care aid than the actual nurse... I also think too, sometimes I think it would be better if we got rid of the health care aids and have a smaller assignment, but do the entire care. (Samantha)

It is a very tough life. It is much more than the physical stress, the emotional, psychological, the day in day out of giving, it is not getting back...The shift work, the long hours, 10 - 12 patients each during the day shifts (on the floors) you are run off your feet, you can not take care of yourself. When you deal with death and dying on a daily basis, you feel part of you dying at the same time. Yet you have to pick up [immediately] another patient who is there. Who is going to do the debriefing. (Anna)

In this section participants talk about disappointments they experience in nursing. How they 'do not want to be' comes thereby into clearer focus. Samantha above deplors how the current realities put her in the position of managing lesser skilled workers who do the actual hands-on care. On the one hand it entails more responsibilities; yet it often prevents her from providing the holistic care she went into nursing for. She even questions if what she does is still nursing. The participants all agree on nursing being 'tough'. Not only is it 'lots of work' but it is also emotionally taxing. Anna describes the hardships that are daily experiences of nurses. She also, once again, deplors the ongoing deskilling, which she attributes to the continuing influence of the patriarchal system:

'Deskilling' of nurses' work should not be acceptable...[there should be] more health promotion before people get sick, nurses should do the teaching about that...nurses are ready right now, but is society ready? No. Are institutions ready? No. Is the hierarchy ready? No. Are the 'boys' willing to let go of the power? No, they hold the power.

As they are forced into undesired, stylized roles, she believes the perceptions others gain of nurses lead to the ongoing devaluation of nursing:

To be valued, we are not. It is not selfish to care for one self. We [are perceived] as having no personal lives, no families, we are not [seen as] worth taking a vacation, we have to give this unconditional commitment to the organization. ...You are supposed to be knowledgeable to do all these technical things, to be eyes, ears, nose of the physician, you are teaching, tolerating families and patients...but you don't get credit for it.

Kathy maintains that in the beginning nursing was what she had expected, but no longer. "I guess it just goes back to people's attitudes now, people I work with. Before I used to come across so many positive people. There were not as many complaints back then, whereas now everybody [nurses] complains right when they come through the door...". Jack had been surprised in the beginning of his career, for the most part pleasantly, about nursing. Yet today he feels disappointed, particularly about the amount of paper work, the loss of team work and 'esprit de corps'. Irene similarly is disillusioned over the non-nursing tasks and the paperwork that take her

away from patients. 'Being with people' had attracted her to nursing and motivated her to persist in the face of all her adverse experiences:

I had no idea of the work involved, I knew it was going to be hard...The paperwork! I never knew there was so much paperwork as there is! We do GRASP [a system that breaks caring work into a series of tasks, which have an allotted time factor each] where you have to rate each patient that you take care of -- if they are able to bath themselves, that is a 3 -- every single day and then your floor gets funding. I don't really know what it does, but there is so much paperwork with people! And the part I like is being with people, I did not really want to be a secretary any more.

She also deplores having to take short-cuts -- which means focusing on the tasks at hand -- "just to get through. That is being a task master really". She further mentions lack of consideration with scheduling to accommodate the other demands of nurses' lives.

Derek is particularly disappointed by the lack of respect and support from administration, the public and even nurses for each other. Conflicting loyalties for nurses in management seem to contribute to further increase nursing's internal rifts:

Well, I expected ... the respect factor... and not just getting respect, but giving respect as well [to each other]. I thought I would be treated better, I think, valued more... I guess we are treated much worse and we are treated badly by each other sometimes as well. As nursing takes on different educational aspects, and hospitals are smart enough to bring nurses into management, I think that sometimes creates infighting. Instead of supporting each other and respecting our profession, again creating hierarchies for each other.

Jennifer is disillusioned with 'lots of changes' she lived through during her career, including the increasing technical rationality of nursing at the bedside.

We have gotten very technical, machines, silly props...all kinds of fancy gadgets. Lots of technology...awful! And then with this emphasis on education...they are turning us into glorified supervisors. When I first got there they had RNs in charge and a mix of RNAs [registered nursing assistants] and health care aids. And then they changed the mix. And now, I hear that they are going back to health care aids. And at one time they abolished all the health care aids and said they wanted

professional people, so it had to be RNAs and RNs. They are putting RNs in charge and having them work with health care aids, except like they got different names for it.

Next she describes the nurse's role in the reorganized system as incongruent with her own ideas of nursing:

So now they have sort of pushed the envelope, they have stretched the boundaries and they are giving people more responsibilities and put them in areas, and they have sort of made the nurse a glorified manager, so that she is doing very little hands-on. She is servicing machines and running up and down and she is responsible for the work and the performance of a whole lot of other people...absolutely more of a management position. I am looking forward to getting out, because it's been so many changes in the last ten years, my head is spinning. Truly!

Craving recognition, which is also discussed in the previous chapter on relationships, Corinne sounds quite desperate when she talks about the lack of praise from her manager in particular: "I am so dissatisfied with what I am doing as well as I don't get the appreciation from the higher bosses... because you know that the managers don't care about you, so why should I care? So you don't put in a 100%. Lack of appreciation!" Irene entertains similar thoughts. She also has suggestions for nurses, specifically managers, to acknowledge each others' achievements more, giving praise where it is due, instead of the constant criticism in which their relationships seem to be grounded:

But I think if a nurse feels she [sic] is not taken for granted, she is respected and that she is doing a good job...I don't think people are praised enough. We don't have to have someone to pat us on the back everyday and say thanks for coming in....but for someone to say, well you really handled that well and you made a difference over here...people are too quick to point out what you did wrong, or maybe not wrong, but they could have done it in a different way...they never let you forget that... But they never come up with, you did a very good job there, you made a difference for that lady, she really perked up after she talked to you... I don't think there is enough recognition of the good we do.

Confirming the long lasting positive impact of praise, Ronnie reminisces about a good

relationship she had experienced with one of her managers as a brand new graduate in her first job, in which she felt supported:

Things I had done, things I was not aware that I did well, the next day I would get a note from my head nurse, 'I know you had a busy night, dadada... But I appreciated it and I have kept... I saved it, you know. Those are small notes, it does not have to be a big piece of paper, small pieces of paper, that really boosted my morale... I am more happy working. Like, when things go wrong and things go bad, I know I have the support, I know people are with me.

Kathy believes that if nurses are more appreciated, "if you are starting them positive too, maybe they will start feeling good about themselves, build their self esteem, maybe get better performance... and so...Everybody will start feeling better".

Corinne expresses disappointment that many nurses seem to think poorly of their own discipline: "A lot of the older nurses at the hospital, they always say, if they had kids, they would have never recommended nursing. That is very discouraging. That means I have made the wrong decision going into nursing. Or I don't know what they mean, it is very bad to hear that and I don't know what to do. They feel disappointed, they do, I could see it". Harrison and Reid (2001) declare similar feelings. They too state that there should be more support for new nurses and more appreciation of nursing as a valuable job, as they state: "we need to know that we made the right decision" (p.27). That few recommend nursing to their own children or those of their friends is also found by Fletcher (2000a).

What keeps the participants going? In order to deal with disappointments Carol learned from her varied experiences that there are times for 'letting go':

So much of nursing, I think, is saying what needs to be said, doing what needs to be done and then...letting it go. If you can go home and say... I know I did what was right, I know I did what I had to do...I may not feel great about it now, but... I am going to let it go.. And as a nurse, if I can keep that in mind for myself, and realize there is always something to learn in a situation...I will be able to deal with the bull-shit, as well as the good stuff, and for me that is the only way I am going to be able to stay in nursing.

Shelly, too, is aware that there are limits to what you can do: "You know yourself! I think that is it, be honest, be fair and put in a good effort. Know that you have done the best of your ability and don't beat yourself up that you did not get to do what you wanted to do. Get to be realistic about what you are facing out there, any job". This attitude is also embraced by Hilda: "You can only do so much. You got to have a sense of humour. You have got to be able to leave it all behind...just do the best you can do".

Despite all their disappointments, and unlike Fletcher's (2000a) findings, most of these participants would still go into nursing again, if they had to do it over. Anna thinks new recruits should know about the current situation to avoid unrealistic expectations: "Would I encourage people to go into nursing now? I would give them the whole story, I would be very frank and let them know it is much more". Samantha: "I'd still do it again, though, yeah". And Esther states: "I am satisfied with being a bedside nurse". Even Corinne hopes to eventually find something in nursing that she will be happy with. Kelly has some ideas, mainly for nurses to take more responsibilities for their own affairs and show leadership:

Hospitals have to give more status to the nurses, more involvement by nurses and nurses to take that on...not to assume that someone else is going to do it for you. We need leaders in our profession who are willing to walk to the end of the tree branch and to look over and be willing to take a leap.... and the more we see each other doing that, nurses right now, there is so much energy...nurses are angry right now and we need to channel that, we can channel that.

Sonya, who is working in a place where the workloads are not as heavy and the nurses provide the hands-on care, expresses satisfaction and surprise about what she encounters: "It is not what I expected, but I really enjoy it and I really like it. It is much more than what I thought it was. Some of it is much worse. It is more exciting than I expected." She feels much more optimistic than the others about her role and the choice of areas to work in: "And there is so much more that you can do with nursing than I expected. It is probably a very different perspective from other people's thoughts on it".

## Discussion

Generally the nurses deplore several points: being forced into the role of hands-off 'case manager' and/or high tech task performance without time for 'being with patients', non-nursing duties and not receiving recognition and respect. Further there is a lack of acknowledgement by others of the emotional impact of nurses' work on them. It can be attributed to the traditional discourse on professionalism. Professionals are to remain neutral and detached. They are expected to see patients as 'objects', as 'others', to be worked on by them -- a 'dividing practice' in an attempt to 'separate the product from the producer' (Foucault, 1982). However, this separation is in conflict with nursing values, as the interpersonal relationship lies at the core. Nurses, as humans deal with other humans, not lifeless objects. They render an altruistic humanitarian service that can be emotionally draining. This aspect of their work becomes increasingly 'invisible' in a system emphasizing the empirical, in which there is no measurement for emotional labour, as it is not recorded within the existing protocols (Baines et al, 1991). Further there is the lack of appreciation and praise, particularly from superiors, who evaluate costs and benefits in an increasingly market driven system.

The 'polo-mint' problem (Davies, 1995), which reduces nursing work to a series of tasks, mostly performed by others, proves the greatest disappointment. It seems to take away what had lured the participants into nursing in the first place or at least what had kept them there. Participants also believe that they would be capable and prepared to contribute a lot more, if they had time and more input. As mentioned before, the underutilization of nurses' knowledge and skills brings up the question, why higher education is demanded at a time when jobs are becoming more and more technical and streamlined into tasks prescribed by protocols. Sonya's comments show that a good education can improve nursing's contribution and satisfaction with their work, but only if given the right opportunities. She is lucky to work in a setting where the staffing is better than average

Most statements show confidence that nursing is still worth while and that change for the better is possible. Yet, through the experience of the realities of nursing and particularly the events of restructuring, participants admit that some of their views became less idealistic. Similarly Tovey & Adams (1999) found perceived lowering of standards of patient care an



important factor in leading to nurses' dissatisfaction. Mitchell (2001) and Webster and Baylis (2000) discuss the felt dissonance as 'moral residue'. In contrast to 'moral conflict' which is more easily recognized and pronounced, it leads to a lingering feeling of dissatisfaction and burn-out. At the same time, a common strategy expressed by some of the seasoned nurses is recognizing limits to what they can realistically achieve, and 'letting go', as Carol, Shelly and Hilda show with their remarks. Perhaps this strategy is too readily used at times. It is a good way to attempt self preservation but can lead to a lack of effective resistance. Its focus on individual coping mechanisms once more helps to maintain the status quo, instead of exploring other possibilities.

To learn more about the participants' visions of the 'socially desirable nurse' and the associated 'truths', in the next two sections we will look at the philosophies that guide the participants' nursing practice, followed by the discussion of the 'ideal nurses' that they would like to be.

## **Philosophies of Nursing**

### **Participants' perspectives**

When you have been a patient yourself, you see what it is like on the other side, or when you have family members who are sick. I love to take care of my patients the way I want someone to take care of me...and that guides my practice. And the same with my colleagues, I treat them in the way I like them to treat me. (Kelly)

When I look at a person, it is their body, mind and spirit. So, a lot of times when I talk to the patients, I do ask them, especially when they are alone, do you have a faith, do you have anything you believe that provides you support? Not just the family, not just the doctors, I look out...so I do incorporate that into my assessment, into my care. (Ronnie)

Several participants, like Kelly in her statement above, feel that the experience of being a patient helped them to 'see the other side'. Kathy applies the golden rule: "I guess what it comes down to is that you treat anyone else the way you want to be treated, if you are in the reverse situation". Ronnie describes looking at the whole person. Others simply mention that they try to

do a 'good job'. That it is 'for the benefit of the patient' is universally expressed. Linda's statement is typical: "To do the best I can for my patients. And that is what keeps me going...". Jack also makes it clear that he works to improve patients' situations and derives his personal satisfaction from doing it:

I have so many different philosophies...my philosophy is probably...to do a good job, wherever I am working. Be happy with the job that I do... At the end of the day being satisfied that I did what I can, everything I can, and been supportive and learned and came away from my experiences...with a better appreciation for what I am doing. But again, also to make sure the patient is benefitted most of all!

Danielle believes that nurses can make a difference in how patients experience illnesses through their knowledge about navigating the system. It is their duty to help them through:

I like to see that people get a good experience when they come through the hospital system...sometimes it is very stressful for the patient and their family...I just like to see, especially bedside nurses to get to know the system, to try and help people through the system...you know, you feel badly because sometimes, for whatever reason, you could have been a lot better...it is part of nursing to help people lessen the impact, even if sometimes you can't do much about the situation...and sometimes things don't work that well and work kind of stupidly... so you try and change that, if you can... So, we have to try and make the system run better, that is what hospitals and the system are here for, helping them get better...deal with whatever happens.

Two of the participants claim that adherence to their religious beliefs guides their nursing. Sarah talks about the influence of her Christian background: "I don't have a particular philosophy of practice other than patient-focused care...well, my own personal philosophy is from a Christian perspective and I work from that philosophy. I do prayers; I am not perfect". This perspective demands selfless dedication, as she later explains, "I am working the best I can, not to please my boss, or to get a promotion, but what drives me is myself, because this person is important...I am here so that this person can go home...for example: praying for patients, give a dying patient a sense of peace, by praying with her". Ronnie too seems to have formed her holistic philosophy of nursing mentioned above by building on her religious values. She claims to derive a great deal of personal fulfillment from 'selflessness' and caring:

What is the core of my beliefs as far as nursing? I believe that caring is #1. Caring is one thing that each nurse should have. Like, without caring it would be difficult to nurse...it accounts for so much as far as nursing goes... I think like for me I am nursing, because I want to care for that person. Not just the physical, every aspect, you know, looking after the whole person...Treating everybody like that and understanding that lives are valuable. ...value life and ahhh, for me it has a lot to do with my faith and beliefs: How I see a person. What we are called to do, Christian teaching, that all of us are created by God, we are loved by him. We love our neighbours as ourselves, treat them as we like to be treated.

Some of the others discuss nursing practice and what it means to them from a more worldly perspective of kinship. Irene's elaborate response is typical, as she talks about treating patients and their families as if they were family of her own:

I always, always put myself in other people's shoes. I feel it is not just the patient, it is the entire family. It is such an upheaval, when someone goes into hospital, or someone is in the community sick. It affects the entire family, not just the individual patient. And you have to look at it from that point of view and I think if this was my family member, I would want them treated a certain way, dignity and respect, and if I was sick, that is the way I would want it. So I always think one should treat others as you want them to treat yourself. ...to the best of my ability anyway...you can't always do everything you want to do, but... to the utmost of what I can do, that is what I want to do.

This notion of family is also echoed by Derek: "You treat people the way you want to be treated. Everybody who is in that bed should be a loved one. Somewhere, deep down, it is your mother, it is your father, it is your favourite aunt." And Samantha declares: "I love to care for people less fortunate than me...and less fortunate than my family...and, when I take care of them, a lot of times I look at someone around my Dad's age group and I look at them and think of my Dad and think how would I like my family to be treated...how would I want the nurses treat them and that is how I try and treat my patients." Jennifer states that in her daily work she thinks about what it would be like to have to go through the procedures herself. She too refers to her patients as 'extended family'.

Carol is a member of the holistic health movement and also practices 'healing touch'. This alternative treatment is based in the belief that illness results from a disarray of a person's

energy fields. Through 'the laying on of hands' by a healer, the energy fields are rearranged for the person to get well again. She believes that it helps "seeing beyond the [physical] body" to expand understanding of human beings. Bruce talks about how two nursing theorists help him to conceptualize nursing:

Peplau, she indicates, also Watson a bit, this entering one's life and becoming a part of it. ...and I think that is what nursing is: interaction, being part of, living with, I like that....The ideal nurse lives with the person. Does not experience with but I think, interacts with, engages with, just part of being there. Our language does not do it very well.

Several of my interviewees come from an institution practicing patient-focused care. On the whole they all agree over the values of this philosophy. Whereas in the traditional paradigm the healthcare providers are considered the experts of what health is and how to obtain it, the goal of this philosophy is to tailor care to the individual patients' needs, as perceived by them, rather than moving them towards established norms. Health and illness are described by the individuals, how they themselves define it, which could be different from the healthcare providers' perspectives. This view goes beyond absence and presence of disease and encompasses the whole person experience. Esther's comments about patient-focused care are typical: "Patient-focused care... I think it is good. When you approach it that way, the patient is satisfied. Yet it is also a personal philosophy, because when I am in the hospital as a patient, I would like this type of care." For her the personal interest shown by the nurse who practices from this theory, plays an important role and is also based in personal experience: "I have been a patient in a hospital and I needed care...that is when you notice it most what good care means."

Linda muses about some of the pros and cons. She also points out present constraints to this way of practice, mainly the lack of time:

The families have been informed about it [patient-focused care] and they are using it as ammunition in lots of areas too, to fight for their rights...Why not! It is not always negative, because sometimes they have the right... I think most of the times they have the right and I wish sometimes they knew what they should be asking... and... mainly in active care it used to be a challenge, because you want to tell the

patient what to say. But you can't say!.. and then they are not getting proper information, especially from the doctor....and because of what you know...they are sort of...left out at times, because you can't help and they are so trusting of the doctor...But now they are more informed and they are asking many more questions. I think they like it this way better. I don't have the time for it because of the cut-backs, but it is much, much better this way.

Kathy, in her comment below, agrees with the philosophy but cautiously points out that she is sceptical about how much it is currently followed in actual practice, based on her own observations:

Oh yeah, yeah, I agree with it. The focus should be the patient...I mean it is the patient...oh well, when you have to bring in the families and all the others, the different team members for coming up with a solution...and things like that... It works out....And then again, you hear so much from the family about the patient not being seen, and then you look at the chart and it has been a few days since the doctor has been in...So, I don't know how much is being done...I can't really say.

Bruce too discusses problems to practicing from this perspective in the current turmoil of restructuring and 'business approach to healthcare', once again pointing at hospitals as the biggest obstacles to actual nursing practice:

Basically taking these courses on patient-focused care have indeed made me feel, yes, it is true what is happening...and where we need to be as a nurse. Trouble is, it is hard to do it where we practice. Today I would say our biggest problems are hospitals. The way they are organized, their philosophy...I think, however, they can not be any other way.

He goes as far as to suggest that knowing this type of practice and not being able to carry it out makes nurses even more frustrated, like dangling a carrot in front of their noses but not allowing them to eat it. And Sarah's comments summarize some other common difficulties which are interfering with the new perspective, such as caring for others when feeling herself uncared for:

I did the course... I am going to take the second part now, because after a while you lose your focus, all the stress and the needs of people and the morale being low...and the stress level of the nurses... people calling in sick and you are short staffed all the time, it gets you down and you find you don't practice patient-

focused care...it feels very frustrating, you need the time to do that ...but at the same time I find a need to understand where the person is coming from is vital...where the patient feels strongly about their history in the back of their mind...we know about the disease, but instead of looking at that [patient's feelings] first, your focus on the disease overrides what you are doing.

She further elaborates on her own struggles in her nursing role between the traditional and the patient-focused care approaches, which she too feels is aggravated by the tensions and pressures of the restructured work environments:

The most difficult thing for me is...I found myself that I had to not suggest solutions or impose solutions on patients...and let them come up with their own goals...and to know whether or not they are interested in suggestions...it is hard to be a nurse when you have to deal with a situation... We have good role models, but the restructuring has dampened the spirits.

## Discussion

By exploring their philosophies of practice we are beginning to learn about the participants' active self formations as 'moral subjects'. Most interviewees talk about their philosophies in practical terms, a perceived moral duty to provide good care. Some seemingly hesitate at first. Perhaps they have never thought about their values until now, at least not consciously. Yet for many their philosophies go beyond duties, often building on and transforming with philosophies of 'neighbouring discourses' such as religion, nursing theories or holistic health practices the participants know about. Spiritual components surface, either based in their religious, academic or holistic health values. Altruism in the forms of 'putting yourself into the other person's shoes', treating patients as they themselves would like to be treated or as if they were 'family', is most commonly mentioned. What all these comments show is that they are based in a humanistic perspective, recognizing the well-being of persons involved over the values of the system. The impression is that nursing transcends being 'a job' into being a 'calling'.

Ronnie and Sarah both have strong religious backgrounds which are influencing how they practice. The image of the 'good Samaritan' is an accepted tradition in nursing since Nightingale, who herself was deeply religious. "It arose from the Judaeo-Christian imperative of care for the

stranger as *agape*" (Bradshaw, 1999, p.477). Carol, an adherent of the holistic health movement, conceptualizes the nurse-patient interaction as exchange and repatterning of energy. Bruce, speaking from a more academic perspective, shows that new conceptualizations can expand visions and change how nurses practice, which confirms the importance and effectiveness of education. A common theme in most of the statements seems to be the belief that practicing their values leads to 'self fulfillment' and personal satisfaction. Previously, in the section about disappointments, we see the 'points of resistance' emerge in the form of their disagreements with and disillusionments over the status quo. Conflict arises when nurses are expected to act in a certain way they see as futile and which hinders their abilities to do a 'good job' the way they see fit. Examples are 'papercare' and statements of 'not enough time' to be with patients and families. Mitchell's (2001) description of the 'moral residue' of conflicts, impacting on nurses' well-being and feelings of self-worth, is mentioned above.

In one institution there is a conscious attempt to reconceptualize nursing at the bedside as 'patient-focused care'. At the same time the policies of this particular hospital are getting slowly reshaped to reflect and become congruent with the philosophy of the patient at the centre of services. Yet these changes take place within, and in spite of, a traditional, paternalistic healthcare system. The five participants involved generally agree that the patient-focused care philosophy can lead nurses into a better direction. Yet, concurrently, fears are voiced about adopting this approach. Lack of time is the most frequently mentioned impediment to this type of practice. It also seems that for many nurses it is threatening to give up the expert role. Linda worries that possessing specialized information could be used by some families to manipulate staff, leaving nurses vulnerable. Then, after further deliberations, she admits that the families' questioning is justified in most cases. These fears reveal how nurses are socialized traditionally to assess and diagnose according to established 'norms', emulating the bio-medical science perspective. In this mode professionals are the 'experts' with superior knowledge about health and illness, providing them with an elevated status vis a vis the patients.

The customary focus is on the illness and the goal is 'normalization' rather than listening to patients' experiences and concerns, what they fear and wish for, and tailoring care to their needs. Through their roles as well-meaning 'experts', health professionals tell patients what is

'best' for them, based on their privileged 'knowledge', thereby helping to shape the subjectivities of their patients into an identity and life styles, acceptable to society they live in. When their 'privileged' knowledge is shared with the patients and families, the nurses fear they could be less often seen as the 'experts', revealing some relations of power between nurses and their patients that are not usually admitted to. Themselves socialized into their 'roles', nurses seemingly are not conscious of their own advantaged status vis a vis their patients that their 'expert knowledge' provides for them. At the same time, within the institutional hierarchical relationships, adopting the role of patient representative holds the potential for deliberately reshaping relationships with patients in more egalitarian ways, more congruent with their expressed philosophies as discussed above. It can provide the nurses with an unique role and distinguish them from the other members of the interdisciplinary team. We will now look at the descriptions of the socially desirable nurses, arising out of the participants' philosophies, and how their ideals fit into the restructured system.

## **The Ideal Nurse**

### **Participants' perspectives**

The ideal nurse would be someone who is well educated, articulate, who balances the intellectual with the caring, someone who is supportive of her colleagues ...who realizes that there are some things we can change and others we can not. An advocate of (w)holistic care, of patient-centred, family-centred care, of collegial recognition amongst the professions who strives not to be complacent with the status quo. (Kelly)

I think confidence is a real biggie, because otherwise they [nurses] have no voice. A lot of them are pretty soft spoken and don't want to rattle the cage....they don't speak up for themselves...who can relate on the whole...to the patient, to the team members, to all the different disciplines, but is there for the patient, advocates for the patient.... hmmm... is self confident. (Shelly)

The above quotations seem to comprise the participants' main ideas about ideal nurses. They reflect their visions of nurses as 'moral subjects'. Kelly's comprehensive description covers the major characteristics mentioned by the participants, including the ability to change and be



confident. Shelly relates confidence to the concept of 'voice', necessary as her image includes a social activist role for nurses advocating for their patients and themselves. Ronnie too sees self-confidence as an important asset to strive for, as it enables nurses "to stand up for themselves and their patients". Kathy mentions open-mindedness and creativity. Irene, more practical, talks about thinking and planning ahead towards when the patient, who needs to be seen as an unique individual, gets discharged. Jack particularly stresses the importance of experience which, for hospital nurses, includes a large experiential knowledge base and handling emergency situations effectively, both of which you have to learn 'on the job'. He also mentions the need for role models:

Somebody who has a good healthy experience and education. Good bedside manners, good patient skills, good people skills, has a very professional demeanor, somebody who is well grounded and unflappable...and as I am speaking, I am envisioning several nurses I am working with right now, who have always been that way. They sort of set the standards, the yard stick toward what excellence in nursing really is....They set an example...and whenever the crap hits the fan, they are able to manage it.

Carol sees the ideal nurse as someone who is always willing to learn and realizes her/his responsibility towards others. S/he loves what s/he is doing, gives of him/herself to the point of 'burning out', once more confirming that nursing is seen as a 'higher calling', not just a job:

...who, from a human point of view has a lot of wonderful qualities... is not...just in nursing for the job...they have to have a heart! They have to want to be there, even when they are burning out, they have to be able to say, I got to step back here for a few minutes and take a break, or I can not stay in this job any more, it is driving me crazy...Because to me a person who chooses to be a nurse has to look at it as a profession and not a job...I don't know how else to word it... I don't think there is a right answer.

Bruce is entering graduate school and appreciates scholarly thinking. He comments on the nurse-person relationship as the core of nursing. As he sees these interactions as always emergent, the nurse needs to be able to feel comfortable with ambiguities and unpredictability. He also describes the gratifications he receives by engaging with his patients, entering the

'inside' of their lives:

My ideas of nursing now, that is why I want to go back to mental health nursing, I do more real nursing there... it is more geared to struggles with unsurities, it's not cause and effect, you are not working even in a medical line of disease that can be cured...it is unpredictable... personally I have often felt closer to the clients with mental illnesses or other clients, who experienced incredible ostracism from society... I have always liked to work with the worst of the worst kind of thing, society's term, not mine... I don't want to change pads, pants, tubes, pills, I want to do some more, something else... and it did not come to me until now, but you become part of...you are not outside.

Jennifer, elaborating on the importance of working together, discusses how the individual differences among nurses should be seen as assets, not liabilities. In her opinion, beyond a common ground to ensure basic, safe practice, it could be advantageous to exploit the diversity of talents nurses have, to the benefit of patients:

Ideal nurse, is there such a creature? I really honestly don't believe it...some people are good at chatting and making patients feel emotionally and socially well, and some people are just very good clinical nurses and they have excellent anatomy and physiology backgrounds. And other people are more geared to paper work...you kind of have to work together as a group...the whole thing is that at the end of the shift those people, that were under your care, have gotten what they should and that you have done the best job that you can.... as long as we learn to do something like a standard body of work and do it socially well...it is as individual as your personalities... something like entertainers, one guy dances well, others do other things well...we all bring a little something different. [As long as] there is a basic body of knowledge that we all adhere to, know medications and their side effects... get somebody up safely.

Diane seemingly summarizes that the ideal nurse is open-minded, questions and collaborates with others, asserts him/herself, shows good communication skills and works well with co-workers. She adds the importance of feeling safe enough to ask questions when not sure:

Someone who is smart, not afraid to question anything...and cares for their patients...everything else you can get by with except... if you are arrogant and think you know everything, or if you are afraid to ask questions because you may look stupid... I am always asking questions, even if I know the answer... even just to listen, or something is being done and I am going, that is not the way it has

been done before, why are you doing it? I love to know why people do things, or their reason...you see a lot of mistakes being made, when people assume too much. Just being a good worker...collaborate... I think it is a huge part of any job.

Samantha, as a new nurse, comments on collegial support: "If you have a junior nurse to be supportive to her [sic], and guiding other nurses [as a senior nurse]... just caring and very helpful and stuff". Irene, also new, in a similar vein: "...somebody that does not forget that people are new and have to learn...and is willing to open up her arms and embrace anybody that is coming on the floor and just show them things". Shelly also seems to recognize caring for colleagues as vital, as she shares her vision of the ideal nurse. She recommends nurses begin by becoming aware of how they talk about each other and not to berate each other. She believes they also should care for themselves to prevent exploitation and resulting burn-out:

...and [s/he needs to] draw the line in the sand and say, this is it! Oh yeah, it is always a big guilt trip, even when you call in sick... here I am 'put the patient first, put the patient first' and 'oh yes, you have to work overtime because what is going to happen to the poor patient'...'yes you have to do this, because... you know all these support workers are not here any more, then who is going to do it?' So I think they need to be looking at both now...we certainly have to be patient advocates more so than ever, but I think we also need to be our own advocates as well... taking care of people who are sick, but you are not allowed to [be sick]...and then again you are not supporting one another. So and so called in sick...again! It is like, what do you expect when you are stressed to the gills, you call in sick frequently...yeah, and probably sometimes you are sick and tired of work and you probably need a mental health day.

Anna too mentions, once again, that 'caring for self' is crucial for nurses. She also feels, it is not an expectation that others hold of nurses, such as management and even the public. Like Shelly she believes that employers take advantage of nurses' work ethics, such as 'being there for patients', 'putting patients' needs first', to render them compliant with the demands of the system, also discussed by Fletcher (2000a).

Some of the more recent graduates seem also aware that they have to stand up for themselves, 'as no one else will do it'. Irene, new to working in a hospital setting, talks about some difficult situations that she encounters with her co-workers: "...it seems to me that I heard

this before... nurses always eat their young. And I never knew what it meant, until I went [to work] in the hospital". Having known difficulties in her life all along she believes helps her in facing adversities. She relates how two of her colleagues kept putting her down repeatedly. Irene felt that she should defuse this situation in an assertive and open manner, as this statement shows:

So, I talked to her and said: 'this is what I am seeing from you and I don't like it. When I first met you I liked you very much. But I feel such a wall coming up between us. I would like to know how you are feeling about that, because it is bothering me. We have to work together... the patients don't need us glaring at each other, I got to get this out...'. But there is also another one, she is permanent nights, that is really bad. I am going to have to talk to her. Oh my God, this is stuff I never thought I was going to have to do. But I am going to resolve it... I mean no one is going to come up on my behalf and be my Mommy and say, she is a nice girl, you don't have to talk like that to her...(laughs). I have to be grown up and do it myself, that is all.

## Discussion

The ideal nurse is portrayed by all participants as smart, knowledgeable, skilled, compassionate, creative, confident and loving her/his work. For all of them nursing is "more than a job". These images clearly go way beyond the portrait of a nurse carrying out a series of prescribed tasks, as it is projected on them in their institutions. For the participants, nursing needs to be learned at the bedside, as class room learning alone will never do it. It involves role modelling and mentoring. The descriptions seem a far cry from nursing's actual role in the restructured system -- as discussed in chapter five -- in which they deliver total patient care in isolation from their colleagues and lack time to 'be with' their patients. In addition there is less practical experience now for students and decreased orientation times for new staff. The main concern for these nurses, repeated over and over again, is that "the patients get what they need at the end of the day". In order to practice individualized care you have to ask patients what their needs are, instead of assuming to know what is best for them. Sonya, as a new baccalaureate graduate, learned about this important point interestingly enough not in her theoretical courses -- even though it had been taught in her program -- but from the interactions with patients themselves during her practica: once again, her experience confirms the importance of the hands-

on opportunities to consolidate theoretical learning and make it come to life. Yet, despite all these ideals, we also heard earlier that nurses do not use all opportunities to interact with their patients, even when they do have the time. And some are said to be openly uncaring.

Patient advocacy or 'representing the patient' is almost universally stated as an ideal. We also heard that in reality nurses sometimes fail to bring forward their patients' perspectives, as they would rather just go along with what the 'inter-disciplinary team' decides. Some remain unaware of their own contributions' value, as we saw in the previous chapters. They feel out of place in committee meetings amongst the rest of the team, wondering what it is they have to contribute. To be an effective advocate caring alone is not enough: a nurse needs to be able to speak up. That is where the self confidence piece comes in. These statements support McGregor's (1996) conclusions of 'confidence-building versus information building' as an important goal of nursing education. Some participants, Anna and Irene in particular, also include caring for self and standing up to others, as 'no one else will do it for you'. Without caring for themselves first they feel that caring for others can not take place, which is also an assumption in Watson's (1985) theory.

Apart from caring for selves, patients and their families, several participants stress caring for co-workers. A significant quality that the ideal nurse possesses is to be kind and helpful towards other staff members, particularly new graduates. It comes, not surprisingly, mostly from the nurses who had recently joined the discipline. However, it is also mentioned by several of the old-timers. As discussed in chapter five the turmoil created by the recent bumping and lay-offs seems to have sensitized many towards this issue. It is also shown in the previous chapters that kindness and support is mostly far from what the participants, particularly the recent graduates and those new to an unit, actually experience. Upon reflection, however, the nurses seem to recognize the importance of nurturing their own.

Jennifer's suggestion to value nurses' diverse talents is in sharp contrast to unquestioned 'conformity', historically the aim of nurses' training (Ashley, 1976/1997; McPherson, 1996) -- clearly undesirable and too restrictive in her eyes. When docile nurses obediently carry out orders it serves institutional and physicians' needs, not necessarily those of their patients. Today the nursing roles created during restructuring are of individuals 'fitting into' predesigned job

descriptions within the system to increase its efficiency (Davies, 1995). Consequently institutional goals are often in conflict with nurses' own perceptions of their work, which is about rendering individualized quality care to their patients (Campbell, 1992; Padgett, 1998). As discussed in previous chapters, by recycling old disciplinary tactics that hark back to historical roots, top down organization and domination persist, and now even more than before come from outside of the discipline (Davies, 1995).

However, growing awareness brought about by education, new ideas, a broadening of the field of possibilities along with nursing's own expanding body of knowledge, also hold the potential for engendering effective counter discourses. Strategies of resistance might come forth from nurses themselves, aiming to regain control over nursing's own affairs. More active collective resistance is an essential strategy and will be explored next. Bellaby & Oribabor (1977) discuss one of the collective ways to improve working conditions in a discipline as proletarianization. It entails unionism and, if necessary, strike actions. A second form of collective action is professionalization. The nurses' views on both these strategies are now explored.

### **Proletarianization in Nursing**

#### **Participants' perspectives**

Well, I don't know who is looking after the patients when they are striking... Sometimes it is like, if that is the only way to get your voice heard, if you try everything, and no one wants to listen with the normal routes of trying to get information out, then sometimes you have to go out... as long as the patients are safe and taken care of... even though you are a nurse you should still be heard. (Irene)

Striking? ... striking... I personally would not strike. I would rather be doing something different, like writing a letter, or something. Well in this area, I don't have much experience as to what I will do. I don't know. (Corinne)

A question on job actions was added during the pilot study when Anna suggested it as an important topic. She sounds cynical and angry, anticipating the public's reaction towards nurses in such an event: "Should we strike? God forbid. Families would think that we are basically very

selfish...if you go on the street, protesting, very un-ladylike, nurses don't do that". Like several others she also envisions an alternative solution involving the nurses collectively, as a preferred strategy: "I would love us to be able to work together, as a unified group... and become politically active, to change things... rather than have[ing] to say: Well, we are not getting what we want, so we must be able to strike! You have to be able to influence the policies... from the grass roots level!" As at the time of most of the interviews the Quebec nurses were on strike, this topic comes up naturally in the course of the discussions, often before the question is asked. Similar to Irene's comment above, most participants feel that sometimes strike action is the only way to be heard.

Like Irene, Shelly uses the voice metaphor: "I mean we had no voice and they were not listening, and they certainly were not taking us seriously, and I was in full agreement. If they had taken us to a vote and said we are considering strike, yeah certainly I would strike if that is the case, because I think that is the only way we are taken seriously." She, like the two men below, seems to have few qualms about striking. Derek expresses strong support:

Definitely! Right on! I am proud of those nurses. I think it began as a cohesive group and unfortunately it is going to affect patients, but nurses will never completely walk away. Essential services are kept. It is a valuable profession and if you are doing a job that is important, that is valuable, then you should have the guts to stand up for that, and stand up for yourself, and effect change! The nurses have been treated terribly, have terrible working conditions!... these are educated people saving lives! I am proud of them!... if more people stood up, as a collective group they could effect change. Because I mean, we are the people looking after the patients, 24 hours a day, not the doctors, not the administrators!

He wishes that the Ontario nurses union were stronger and would also go on strike, as long as the patients are not being compromised. He also believes that asking for self will benefit the patients. He too recognizes the importance of caring for self, previously emphasized by Anna: "You have to value yourself, make yourself happy, before you are going to help other people. And in the end it is only going to help patients". Similarly Jack, referring to some of his experiences from his other job, states:

There are only 3000 members in my [other] professional association, and they do a tremendous amount of organization and lobbying, and they get great respect, they have great cachet, and they have great benefits, great perks, great salaries, great hours, great esprit de corps, good camaraderie... and these are issues... and... experiences that I could take to nursing! That would just enhance nursing dramatically, instead of these bullshit, crappy, unimportant research programs that are being initiated by CNO, ONA and RNAO! It is just so easy to organize and just so easy to inform and educate nursing and the public as to what nursing really does and so... there is just so much that is not being done to help nursing now, I just find that incredibly frustrating! ONA is out of touch!

Danielle recalls how she felt disappointed and taken advantage of, when no one had cared for the nurses and their families during the recent lay-offs: "As nurses, they say you can't strike, oh my goodness, everything is falling apart, but yet, you are getting dumped on".

However, most of the other participants struggle with reasons for and against the strike issue, showing discomfort. This ambivalence is captured when Samantha comments on the Quebec nurses' actions: "They are dealing with the same stuff that we are dealing with here and I think that nurses wouldn't really do it, unless they are pushed up against the wall...kind of thing." Corinne, quoted in the beginning of the section, expresses the strongest scepticism and also favours alternative actions like media campaigns. Carol seems to agree with her:

There is a big part of me that says: Go girls! Go girls! Do what you got to do! And the other part of me says: hold on, this is not the way to solve the issues... this is not going to get you anywhere, but in the hole! Ahh... and in the long run... it's going to lose you a lot of support from the public, whereas, if you moved on a more media extensive, politically active kind of situation, you might continue your public support, and gain more of it!

Ronnie states less enthusiastically:

Strike? Personally that is not something that I would like myself to get involved in. But, as far as now the way I see things... that is the only way they can do it...things are in a critical situation right now, as far as the nursing situation, if they want anything to change, that is the way they have to go. Sounds very aggressive but...

Sonya ventures quite timidly: "Yeahh... I think it is good that they ask for something that is fair,



but not too much... because I see it from both...points of view...". And finally Kathy seems uncomfortable with female 'aggressiveness', which does not seem to fit her notion of appropriate femininity:

I don't know what it is about the head of our union, but she just sounds so aggressive every time she talks.. Like she does not talk like a negotiator, she is always on the attack! Like in her position I wished she was acting more professional in a way... like a professional voice for all of us,... just to give us a whole different image... like so that people will.... take her seriously.

At this point, however, she deliberates about women and their position some more: "Of course there is something about women... I mean do we women have much voice in anything... I mean we are always stepped on... If there were more men in the profession would people take us more seriously?" I point out to her that the Quebec nurses are mostly women too. She then muses: "Mhm. Maybe they have a man doing the union job...". When I reply that no, their president is a woman, she laughs, "people feel more sympathetic towards women than men sometimes...Like the weaker sex... single moms with kids to support."

## **Discussion**

Ponte, Fay, Brown, Doyle, Perron, Zizzi & Barrett (1998) examined factors leading to a strike vote amongst the nurses of a particular hospital. They found that a lack of administrative responsiveness to their concerns, fear of change, resistance to use of unlicensed workers, reduction in job benefits, workplace health and safety concerns, and inequities between salaries of nursing staff and senior executives were perceived as the main reasons for striking. Their findings seem very similar to many concerns identified by the nurses in my study. However, many of my participants additionally express that deteriorating patient care and their concern for patients are major factors. They also feel that their own well-being is to the benefits of patients, as it enables them to provide better care. The voice metaphor and 'not being heard' is once again evident in several statements above.

In this section, more than anywhere else in the interviews, conflicting discourses come to the surface. Strike action is not an easy topic for the participants, who enjoy 'helping others' and

whose goal is alleviating suffering and improving other people's lives. Many are clearly ambivalent, 'divided within themselves' between their commitment towards patients, as they know that patients will be inconvenienced at the very least, and their own desires to be heard, respected and rewarded. Most of their first reactions are to declare concerns for patients. Additionally there are apprehensions over how they want to be perceived. Selfless dedication, historically an important characteristic of nurses, still contributes strongly to how they constitute themselves. Sonya is afraid to 'ask for too much'. Several feel very uncomfortable about being seen as 'aggressive' and 'unlady-like', showing how discourses about women contribute to their subjectivities as nurses. This aspect is expressed most clearly by Kathy. She is not comfortable with the idea of nurses asking outright for themselves as her criticism of the union leader's style shows. Most appropriately, in her view, the voice of a woman should be a very specific voice, a 'professional voice' or a 'woman in distress voice'. Even though she concedes the need for action she holds strong convictions regarding how women ought to go about 'asking for themselves'. She is obviously more comfortable with traditional 'feminine' strategies than 'aggression'. As some participants are torn between being 'gentle and nice' and 'aggressive', inner conflicts as dividing practices, are evident. While the old subject positions of selfless dedication and sacrifice for others shine clearly through, there is also an emerging new-found militancy as they go on to express approval and understanding for the striking nurses.

Jack and Derek, in contrast, seem to transfer the 'male' working class perspective on strikes to the 'female' discipline of nursing. Yet they too are keeping the patients' well-being in mind. Asking for 'good salaries and benefits' and 'respect', lobbying and organizing to improve their own conditions, as well as taking job actions, seem more acceptable for them as men than most of their female colleagues. Yet Shelly and Jennifer also have few qualms, showing how different discourses shape subjectivities and are taken up in different ways by individuals, therefore always producing varying and heterogeneous effects. Most other participants however see strike as a 'last resort'. Several would prefer an alternative route through negotiation, media campaigns and political action. Yet, in the end, they also see striking as justified under the circumstances. Some go as far as to express dissatisfaction with their own nursing unions, as they describe them as largely ineffective. With the exception of Corinne, who admits that she does not

know much 'about these things', all who were interviewed during the time of the strike express their understanding and support for the Quebec nursing colleagues -- a perhaps surprising show of solidarity when considering that mutual collegial support at the practice level is sorely lacking. This seeming incongruency too supports Foucault's assertions that discursive practices are taken up differently at different local levels. A fluid 'interdiscursivity' or 'hybridity' of discourses (Farrell, 2000) is performed by each of the nurses, as old and new ones intermingle, denoting the ongoing struggle and changes that work place identities undergo.

As it turned out, during the strike, there was a lot of public support for nurses, which suggests that many members of the population are beginning to recognize nursing's plight, again probably not what administrators had expected of the public. The Quebec strikers cleverly integrated concern for the public's interest as a major issue during their campaign. As with a few reservations the participants supported strike action, a change from my previous research findings (Daiski, 1994) is evident. At that time, at the early stages of restructuring, half of the nurses I interviewed felt that unions were inappropriate for them, and strikes were deemed unacceptable by all. My data also support Fletcher's (2000a) findings that nurses are slowly becoming more militant. Perhaps the nurses that are left in the workforce now are rethinking their attitudes. As the recent events of restructuring obviously caused a lot of disillusionment amongst nurses their altered awareness seems to lead towards different relationships with themselves. They slowly become comfortable with seeing themselves as 'asking for themselves', showing the impact that restructuring had on their perceptions of what counts as appropriate conduct. If the loss of job security was designed to increase their docility and compliance, the results turned out quite different than expected, illustrating the heterogenous and productive effects of power. Next, I turn to nurses' ideas on professionalization and associated higher education as the second major collective strategy.

## Professionalization and Higher Education

### Participants' perspectives

We are a profession in process...because I think we are now starting to see our unique identity...even though it is two steps forward, one backwards. I think we are seeing...we can practice nursing if we take away the doctors and hospitals. That was always my query, if you took away the hospitals and the doctors, would nurses exist? And in my mind they are now starting to exist...away from those things, and therefore I think we are more on the way of becoming a separate professional body. (Bruce)

No, it [nursing] is not a profession, I tell you why. We are the jacks of all trades as they call us. Because you find that you are doing everything that nobody else wants to do. There are things like... even cleaning the floor. Why would we take a mop to clean, because it is not nursing!? Why would we be writing doctors' orders? That is the doctor's work. So, a profession is, when you can define, you have a job description, a directive. But we don't have anything in nursing yet, where it is defined what we can and can not do... not well... there are some guidelines and standards...but there are other...lots of things we do and they are not in there. And the doctors...everybody tells us what to do. (Linda)

These two opposing comments seem to span the range of the participants' diverse thoughts on the issue of professionalism. Bruce believes that nurses need to create and become more aware of their unique contributions and to delineate their own knowledge against that of the other professions. The focus should be on what nurses do independently without needing a doctor's order, their autonomous functions, and that they should move more into the community and self-employment:

I think the biggest obstacle to the professional development of the nurses is the hospital. I think it robs their autonomy typically..... and also nursing education in the past. We had so many really wonderful nurses that wanted to go in and become a nurse and they have been formed, turned and ironed and changed to suit the school and the hospital. I think we almost have to compromise, working in hospitals, but I think if we were not struggling with the hospitals we would die, that keeps us alive, that keeps us focused on what we should be doing...because we feel the tension in our life if we don't do it.

He sees hospitals simultaneously as holding nurses back, yet inciting them to clarify their own goals and values. He emphasizes, once again, that nursing needs to define itself more: nurses taking more initiatives in their own affairs and getting out of hospitals, out from the existing hierarchies, as 'deskilling' of nursing care and its increasing down-loading to lower paid workers 'is happening anyway'. He believes that reflective practice might be helpful and could be taught to all, including the nurses already in the system, as they need to become clear about what nursing means to them:

I think we need more understanding of ourselves, and that is done through reflection. In terms of relationships, I think nurses need to maybe look at that part of their practice. I think we also need to look more at understanding what human is, and what health is in the meta-paradigm. It sounds really academic, but I think that happens with reflection. What is nursing? That is where nurses need to grow up and we are starting [to do this].

Anna too feels nurses should become more active in their own fate, pointing to autonomy as a sign of professionalism. She discusses the ambiguity that surrounds nursing and other female occupations: "It seems you value what I do, but not how I do it, or what I say about it...you just want me for just parts of what I do... Maybe it is because we are a female dominated profession, I don't know...or maybe the culture, society, how we have been socialized, this is women's work, be it in the hospital, be it in the home, where ever...". She is even suspicious of feminism. In her eyes it "has not been a lot of help to us, I don't think...there are still negative connotations adhering to feminism. We got to figure it out ourselves, before we ask someone else to do it for us".

Linda, quoted above, further points to the consequences of being a female occupation. She believes nursing is left with everything that no one else wants or is required to do. "How then can we call ourselves professionals?" she asks. "[For]one thing, because we are... used to be...we are a female career, our role is nurturing. I think that is why we are stuck doing what we are doing today, we are still mothering people", alluding to societal expectations. She feels it will only get better with "the number of men in nursing approaching half of the work force". She believes them to be biologically different and more assertive: "Because they [men] are not the

same, we are made of different hormones... and they are going to say: no, I can't do that! Because it is not part of them. We are used to cleaning the floor, so we just take a mop. We don't even think twice...". Danielle similarly states that the non-nursing tasks, like house keeping and clerical work, impact on nurses' self-perceptions: "It does not make you feel as a professional".

Derek seems to agree. He further suggests that nurses need to look at how they actively participate in creating their present situations. As a start, he thinks, they need to learn to 'set limits'. He uses a story about laundry bagging as a non-nursing task that is not patient-related. When he first began his nursing career he refused to do this chore. His argument was: "I am here to look after patients. If I do that, the next thing, there is a washer and dryer and you want me to wash it". Therefore he had argued that other workers should be hired to do it, as "it was not a bad job, but not what I was paid for. And it is not arrogance, and it is not desertion...you have limits. And if you are willing to do everything, we affect other people's jobs as well". However, many of his female colleagues, having 'always done it', continued to bag the laundry without questioning. Getting no support from them he eventually gave up. Jack describes a similar experience with laundry disposal. He was "shocked" when he saw "nurses carrying heavy laundrybags way down the hall." When he refused to do it some of his co-workers, "little women weighing 100 lbs.", would carry his bag as well as their own, which made him feel unchivalrous. He therefore grudgingly gave in and, like the rest of the nurses, began to carry his bags.

For several of the participants it seems self evident that nursing is a profession. Irene sees nursing as a profession because, "it is not that everybody can become a nurse. You have to have the qualification to become one. The standards are there." Samantha talks about innate characteristics, combined with education: "You have to have it within you to be a nurse...not just anybody can come off the street to be a nurse, you have to be educated and you have to be very knowledgeable and skilled...". She mentions the College of Nurses guidelines. For Carol too nurses seem to possess some special characteristics, "because I don't believe it is [just] a job. I think that anybody who is a nurse brings nursing where ever they go...they can put a real human perspective on it..., because it is part of who they are...".

Knowing that one of the hallmarks of professionalism is an university education (Cohen, 1986) most participants hope that the degree requirement will help to value nursing. Yet,

simultaneously, they deride the preparation universities provide, believing that it gets you status, but less competence and skills. Kelly, herself baccalaureate prepared, supports the idea of university education for nurses. She believes that an education including liberal arts will help nurses to become more 'articulate', as opposed to the past, when the virtues of silence were promoted. Being heard, she believes, will enable them to be more active in shaping their destiny. At the same time she describes nursing as demanding maturity and know-how, "... not only for the physical stuff that you learn, but also the emotional, it needs maturity, it is a tremendous responsibility to be a nurse. Coping with deaths is taxing...". Ronnie too firmly believes in education:

What will make a difference: education, I am going back to education again. It really puts new ideas into people's minds, allows people to explore, open up their eyes to see, but that alone, if all nurses have their degrees will bring changes, will be a change from nursing now. They will find new ways of doing things, new ways of being involved and getting things changed. They will be more...self confident in bringing forth their rights. When they get involved with committees they have more things to bring with them, to speak up for themselves.

Jennifer is convinced that the right combination of experience and education is very beneficial. She describes herself as having experience but lacking education and therefore can not "see the forest from the trees. But the nurses that have the higher education and have done some clinical work sort of take a step away and learn a little bit theory...they can see the forest". Shelly also sees higher education as going along with professionalization:

What constitutes a profession? One of the traditional markers is a university education... it certainly is more than just a nursing perception, it is a public perception. So if you had a degree you were probably perceived as better. I don't think necessarily that a degree makes you a better nurse... I mean we see that all the time. We get someone who comes straight from university to the bedside, and if anything, the clinical skills are lacking. That is not what they are trained for, that is not their focus... but, how many degrees do you need out there?

Later she points to other strategies that she sees also as important: "But I think nurses need to take more of a verbal stance... and start voting and attending meetings and bringing about change. And I don't know...it does not take a degree to change nursing, it takes more input from

us...I don't know, I think it is because we are a predominantly female profession. For a lot of women it is a part-time job...", recognizing the current difficulties created by casualization, which further enhance the disadvantaged female occupation. She fears that the current demand for more education facilitates getting rid of nurses with high seniority who are paid the most. While it is promoted by nursing leaders as a mile-stone on the road to professionalism, she sees it as exploited by administration for their own purpose as a new strategy, to further the goal of 'bottomline':

But, you know what, now they are laying off people with seniority, because it is costing them more than hiring new grads. And telling you they want degree nurses...they are not getting degree nurses, they are getting fresh grads with degrees...and they are using the degree as cover to get rid of them [the senior nurses]. They are mostly young nurses that are being paid less. They are looking for cheap nurses. Hospital administration does not care, whether you have a degree or not. The professional bodies do, but not the administrators. And people who are working on their degrees are more likely to work part time, so you don't have to pay them benefits. And they will work anything, because they need their money to pay their rent and their tuition. Probably there is somebody somewhere in a back office, discussing that.

Esther talks about resulting pressures on nurses she perceives as unrealistic and unnecessary. With the recent developments continuous upgrading is demanded by employers as well as the College of Nurses and there is a push for getting a degree, even though previous diploma graduates are supposed to be 'grand fathered' and therefore exempted from obtaining a degree:

You work and you still got your family to look after. They expect that you upgrade, have reflective practice, peer feedback, and you have to do all these umpteen things and...you don't have the time! I am over 50, I will retire, so I don't want to do any more my BScN. A few courses yes, one course a year, I don't have the time to do more. Right now I am satisfied with going in and doing my work.

Carol has the following to say on the issue of baccalaureate education, which she too sees as imposed by the nursing elite:

I think there is a lot of people on the 'pro'- side [for baccalaureate degree preparation] that [believe] we will benefit from the transformation. [Yet] some of



the actions have really made it 'con' in a lot of people's minds. I think that there are some people who are too forceful with it, who have not made the greatest decision in bringing the baccalaureate into the practice situation. And because of... some of their actions they have really put a negative force on that...they have raised a lot of things... oh yeah, I am not good enough now as a nurse, because I don't have a degree? It makes other people feel inferior...it is in their actions and what they say, that they are creating a dichotomy or a rift between nurses...it may not be their intention to cause a rift... it may not be their intention to make somebody feel inferior... 140,000 nurses we have in Ontario, how many of them have degrees? And these people are getting their backs up because of that.

Even though Carol agrees with degree preparation itself she, like most, is wary of the limitations of this strategy. It might elevate nursing in the eyes of others she thinks but also asks: "if it is not doing that [elevate nursing] on the inside, what good is it?" Other participants too are guarded in their beliefs that the degree requirement will be a cure-all and doubt that the baccalaureate education is going to 'fix all our problems'. This scepticism was most evident in one of Diane's comments regarding the value of more education for nurses: "It is not the answer to the problems... but I mean, we are not going to get more respect from doctors or whoever. I think we are usually looking for the respect from the doctors... but no, not in getting any more respect from the doctors".

Danielle, who holds a diploma herself, is all in favour of degree preparation. However, she too has reservations, once again regarding practical learning:

But as I say, the courses should always include a big clinical part, because nursing is very hands-on clinical, and... some people are just not that way, they don't cut it...they don't talk to patients, they know what to order and they know what to do, but they won't be able to communicate... and for bedside nursing, I don't think that the degree programs do sort of incorporate a big part of that into their program.

She elaborates on why good nursing can not be learned from books alone and why a big clinical component is important, particularly now, as the 'physical' care is often done by other less educated workers who the nurses are supposed to guide:

And...with the patient care going back to the ward aids, health care aids and

people that are just not paid that much, that hold a certificate, basically they [nurses] talk to patients, find out what the patient's problem is and deal with it. To me there is a gap there, like knowing that Mrs. So and So is worried about this or that and her home, you know it is just the whole picture, not just her hip replacement or gallbladder surgery, whatever it is. So, a big clinical component would be very important.

Derek states that improving nursing also involves thinking about and "getting back to basics, it is within our care for our patients", while Danielle describes what is important for patients: they "want somebody who is willing to be there at 2:AM, when they feel sick. That is what nursing is about". Kathy's advice is to focus more on the nurses' common goals than their differences because, "we all want to help people, right?" Several participants go as far as suggesting that perhaps gender and historical traditions are more of a reason for nursing's low status, than the lack of an university education. As a strategy already mentioned in the last section, Kelly calls for getting more involved with the media, "get the journalists into the hospital to find out what is happening. They [nurses] can not rely on what governments are spitting out and telling us", she argues.

Jack suggests that a niche exists for the diploma program particularly at the bedside. He feels that the professional association, "the RNAO... should be combining and unifying and creating a new role for nursing and better direction than fractionalizing it. There is too much fractionalization in health care...", which he blames for the recent devaluation of experience. He continues angrily: "And then you are getting back into these... PhDs of nursing. I mean my God... we don't need these people! They should just fire them, get rid of them, hire some people with grassroots experience, common sense and I tell you the problem would be fixed in no time at all!" Linda too believes that the diploma nurse is "actually more equipped to deal with direct patient care, compared with the degree nurse". She states it takes "degree nurses longer to actually catch on, most likely due to their preparation". She admits, however, that they eventually can.

Sonya feels confident that her education was appropriate and prepared her well. She is optimistic about its value:

My colleague is a diploma nurse. She just graduated too and she knew just so much more than I do, in terms of tasks. She knows how to do a dressing, she knows how to do that IV properly. I don't have that experience, but I have head knowledge, I have theory, I have technology and I can pick my way, like... logically plan things... it is different, but I think it carries you so much further than just knowing that task.

To my surprise the nurses bring up an interesting point, as almost all of them ask the question: "Who will do the bedside nursing, when everyone has their degree?" Jennifer observes, somewhat disdainfully, that most of the ones that become educated leave the bedside and forget about patient care. Here is her description of the 'educated nurse':

They are going to be in charge...the baccalaureate nurses are going to end up like supervisors. So you are going to end up with your nurses becoming supervisors and your practical nurses becoming what the RNs used to do...Ah... I see the ones [educated nurses] that flit around now, they are all in their street cloths and they put a lab coat over and they hang on their name tag and they usually have a book or paper in their hand, and they sort of call you... they walk through the clinic and a patient grabs them and says, I have to go to the bathroom. And they say, just a minute, I get a nurse for you! That is my experience. Because they have become educated they have taken sort of a step higher, you know...sort of I am elite from this, I am a step above.

Esther seems to have the same concerns. She too asks: "What is going to happen to the bedside nurse, if everybody is going to school...". Jack questions why anyone who spent so much time in education would work these "horrendous shifts, hours and put up with the workload for the money they get!"

Corinne, as a degree graduate, confirms these views when asked where she wants to work:

No, no, not at the bedside...I will be so honest with you. I don't know if it is a good thing or a bad thing, but none of the degree nurses want to do bedside nursing. That is a fact. I think it could be possible [they would stay], I did not think about it, but it could be possible. But there got to be major changes! That means a major change in the sense of...the attitude of co-workers.

Reflecting on the future she states:

What is going to happen in 10 years? It is very interesting. Because I myself, I know, I will not work in a hospital. Next April I am quitting. I only want to get my one year experience and I am going to have to get another job, a nursing job, out in the community somewhere. I know that for a fact. It is really disappointing for me, when I went into this, knowing what education, what I am aiming for, what I do and the appreciation that I get and I don't get.

She finds the job of bedside nursing, that had been her dream, disappointingly unattractive.

Carol is upset over what she perceives as a devaluation of nursing, when degree prepared nurses leave the bedside. She asks in desperation: "Is not nursing taking care of people? I am concerned about nursing's attitude that, if I do my degree then I do not have to do bedside nursing. If that is the attitude that some people have when they go into nursing, that they don't have to do bedside nursing, then, what are they going into nursing for?" She then admits after further deliberations: "I think you could have some awesome nurses coming out of the degree program, if you up their clinical hours in the hospital during their training". Even Corinne later states that there could be a role for degree nurses at the bedside: "Can you imagine having a whole floor full of RNs with degrees? You would have so much input towards decision making." Sonya seems to confirm their views. She loves working at the bedside and sounds confident in her abilities to acquire the necessary skills. It has to be remembered that she works in a setting that is much better staffed than most others. She also feels welcomed there, despite being a 'new degree graduate':

You just need to see it once or twice and you will know it. And you will be able to ask questions, if I do this then what will happen? So, find out why it is so, instead of just doing it. And I do find some nurses just do it and they don't ask questions. And that does not help the patient. Because they need to ask questions, they need to critically think about situations. They have the experience, they know what to do at this moment. And if you ask them, they don't know the answer, because they never thought about it and never asked questions themselves. It is part of the job, they know how to do it and they can do it well.

## **Discussion**

The above comments illustrate that the participants are divided on the issue of professionalism and most seem unsure of what a profession is or should be. Some, like Bruce, feel that nursing has the potential to be a profession, as it does show elements of professionalism

-- but is far from being there yet. Linda, on the other hand, denies vehemently that nursing is a profession. She discusses how everyone, including the 'housekeeping girl', has job descriptions that delineate what s/he is expected to do, everyone but the nurses. While it is taken for granted that nurses are doing non-nursing tasks, there are also many other important aspects of their work that are not in the job descriptions. Because they are not formally written out in standardized 'textual forms' for others to appraise, they remain mostly 'invisible'. Yet they make nursing what it is. As discussed before, caring and sensitive communication are examples of ways of 'being with' patients. Their underlying knowledge base is not officially recognized and it is hard to translate these concepts into quantitative measurements in units of time.

Comments from those participants who take it for granted that nursing is a profession seem somewhat fuzzy and limited to certain elements, such as having a regulating body. Of course the same can be said also for any trade, not only professions. Some of their descriptions seem to contain elements that hark back to historical beliefs about nurses 'being born, not made' (Ashley, 1977), such as in the comment 'you have to have it in you'. As these discourses are deeply entrenched in the 'social nexus', they remain invisible and therefore unquestioned for the most part while helping to shape subjectivities. Anna alludes to feminism's disregard for nursing in the past, as nurses were often derided by their own sisters for clinging to traditional female roles (see also Falk Rafael, 1996). Linda, like several others, uses discourses of biological sciences as they articulate with the gender discourses, when she wishes for more men in nursing. Many 'menial tasks' are taken for granted by the nurses in the system and unquestioningly integrated into their jobs. They have long been naturalized responsibilities of women in general, and nurses in particular, perpetuated and reinforced by training them as docile workers. Over the years, to save money, support personnel have been laid-off and their tasks added on to the nurses' duties.

Two of the men tried to refuse carrying out some of the menial tasks, when they first started. Alone, however, they were unable to change these long-standing routines that their female colleagues just continued on doing. At first glance this example seems to support Linda's belief that nursing might possibly change when half the nurses are men. However, in the previous chapter I discussed how some new women nurses in a unit tried to refuse similar menial tasks.

They too were unsuccessful. 'Biological' females also can look beyond the taken-for-granted, showing that divergent thinking is not only a male prerogative but rather gets obscured by popular unexamined and deterministic discourses. In the above example I tried to show that hanging on to traditional ways, no matter how inappropriate, serves as a technique of asserting power positions by the existing staff towards newcomers.

Shelly, with insight, points to the necessity of nurses becoming involved in actively shaping their future. We have seen earlier that 'letting go' is one of the prevalent coping strategies which are often resorted to, perhaps too quickly. As the trend is towards casualization, discussed in the previous chapters, once more an existing hurdle gets actually reinforced by the restructured work organization. Casual nurses are often too marginalized to feel part of a bigger whole and get involved. As, most of the time they are attached to more than one work place, it is hard for them to see their work as 'more than a job' and to develop a sense of belonging and ownership. As well, historically, women were expected to care more for their families than a career.

As discussed earlier, one of the commonly accepted hall marks of a profession is an 'extensive university education' (Cohen, 1981; Larsen, 1977). Sonya describes well the difference between the diploma nurses' preparation for technical performance and the degree nurses' education as knowledge workers. Following routines and carrying out prescribed tasks is not enough. Herself baccalaureate prepared she supports education whole-heartedly and believes that the concern for skills is overrated. She is confident that the tasks can be picked up quickly, yet communication, critical thinking and problem solving are the main assets an education provides. The benefits of liberal arts courses were pointed out by some. Yet several experienced nurses maintain that they also learned 'higher skills' over time on the job. Perhaps formal education is not the only source of higher learning. However it can provide a head start on it.

Surprisingly, despite some reservations, most participants agree that a degree education is a good move -- a finding quite puzzling at first, given their attitudes towards young degree graduates discussed before. They hope that it will elevate nursing in the eyes of others, particularly as many nurses feel intimidated amidst the other professionals and see themselves as less educated. A degree might give them the necessary confidence and skills to become more

involved and visible in policies and committees, which they find beneficial. Yet many do not believe that the degree will be a cure-all; most participants doubt that it is going to 'fix our problems'. Diane questions whether it will foster more respect from doctors, once again illustrating the important roles they play in the nurses' quality of work life. It also shows that traditional discourses and ingrained beliefs might be stronger than new credentials. The danger of a further extension of already existing internal rifts is pointed out many times during the interviews. Baccalaureate prepared nurses, it seems, are pitted against those who hold diplomas. As they get preference for jobs and promotions, one more dividing practice is created, another layer added to the existing hierarchy that separates nurses from each other, and plays out in hostility towards 'degree grads'.

While overall supporting degree preparation itself, all the long-time nurses are upset about the concurrent devaluation of experience that they perceive to go along with it. It leads me to suspect that their resistance is directed not against education itself but against the concurrent perceived devaluation of hands-on work. Several mention that degree prepared nurses certainly have a lot of 'book knowledge' but do not know what to do in practice, as the importance of more practicum experiences for student nurses is brought up again. This view is also supported by Harrison's and Reid's (2001) recent survey. Additionally the nurses already in the system mostly seem to object not to that, but HOW, the mandatory degree education was brought about and imposed on them. As experience appears devalued, they seem suspicious that the degree requirement serves vested interests of the elite groups in nursing. It is also further exploited by employers who redesign jobs to include a degree preparation and thereby exclude the experienced diploma nurse. Today's disproportionate emphasis on classroom education also seems to help justify -- and perhaps obscure -- the shortened clinical experiences for students and orientation programs for new employees.

Jack openly expresses resistance through his contempt for nursing's 'academically prepared' leadership, and their 'academic research'. Throughout the interview he mentions the 'uselessness' of 'these PHDs in Nursing' several times. I ask him afterwards to tell me why he feels this way. His answer is that he objects to those who had never worked at the practice level and therefore do not understand what is going on in the 'real world'. Coupled with experience

education is not a problem he concedes. His explanations, once more, confirm that resistances are directed against imposition on staff nurses from above by others, including their own leadership, who do not know the bedside. He holds them responsible for elevating learning in the classroom on cost of experience. He feels they have 'sold out'.

However, a degree preparation seems to have also some unanticipated consequences: It changes the nurses' own perceptions about their roles, which adds a surprising twist -- they leave the bedside for other positions, community health, as Corinne hopes, management and staff education, as Jennifer observes. The reason why nursing leaders pushed for a degree preparation was to better prepare practicing nurses to deal with and understand the complex health issues concerning their patients. Leaving the bedside therefore seems to defeat this purpose. Yet, paradoxically, as we have seen earlier, most nurses go into nursing because they want to do patient care. Participants speak about 'interactions with patients' as the reason why they enjoy their jobs. When others do the hands-on care they get frustrated. Most see the only 'real' nursing as being at the bedside. Carol, in particular, passionately questions why anyone who does not want to do patient care should be going into nursing at all. This surprising development raises questions about the nurse of the future: Will there be any RNs at the bedside to care for patients, or will they all work elsewhere eventually? Sonya's experience, however, seems to point towards the conditions that are in existence in most places, not university education itself, as the reason. A degree seems to provide desperate and disappointed nurses with a ticket to escape towards something more rewarding. As Sonya works in a more favourable setting she remains content to stay at the bedside, at least so far.

In summary, the participants believe that an universal degree preparation might actually be useful in improving their status in the eyes of the public and other disciplines. It is a step towards professional recognition. However they also realize that it will not solve nursing's problems. Further they resent how it was imposed on them from above accompanied by a perceived concurrent devaluation of experience, which they believe is absolutely essential to good nursing practice. Yet, at the same time in chapter five, we also see a devaluation of knowledge. Routinization of nursing is increasing as jobs are becoming a string of tasks, and nurses complain that their knowledge and skills are underutilized.



### Summary

In this chapter I explore how nurses turn themselves into moral subjects, their self styling practices. The ideal nurses they want to be put their patients first, care about colleagues and, as some mention, care about themselves. They are educated, knowledgeable and articulate. They love their jobs and stand up for others and themselves. They are also experienced in hands-on nursing, treating patients as they themselves or their families would like to be treated. It seems the bedside nursing job, as it is now, does not represent satisfying practice in many ways, despite the nurses' attachments to patients. They feel devalued and frustrated as their knowledge is underutilized and their work and experience not appreciated. At the same time they are unable to perform according to their own standards, due to high work loads and staffing patterns, leading to 'moral residue'.

To a large extent resistance of individual nurses is directed against being told, by others who lack knowledge of the bedside, how they should practice. With the introduction of the degree requirement, HOW changes are imposed 'from above' and without their input, in this instance by their own nursing elite, is once more the most objectionable point. Despite concessions that a 'liberal education' is helpful for bringing in new ideas and increasing 'self-confidence', many feel their years of experience discounted in favour of formal 'classroom knowledge' and a degree preparation. They strongly maintain that both, experience and education, are valuable and necessary. As nursing needs to be learned with real patients, the hands-on component is very important, yet clinical experience and orientation programs have become constantly eroded. Some of the participants maintain that discourses on professionalization have frequently been 'colonized' and exploited by people in administration to their own advantage, such as when experienced diploma nurses get laid off and replaced with inexperienced degree nurses who are on a beginner's pay scale.

Continuing lack of respect and appreciation for their work shown by others is cited yet again as very disillusioning. For some of the younger nurses, especially those with degree preparation, it is especially frustrating to work in the present task-centred system, as their knowledge can not be utilized. These factors lead to comments of 'not giving 100% of themselves' and wanting to leave the hospital environment. It becomes again evident that not

only experience is devalued, but paradoxically so also is nurses' knowledge at a time when more education is demanded. The knowledge learned in universities, in particular, can not be applied in the current system. Underutilization of nurses' capabilities is also reported by Fletcher (2000a) and MacMillan (2000). Combined with unsatisfactory working conditions for degree prepared nurses, who have alternative options, it leads to a sometimes painful abandonment of bedside nursing, even though that is where they wanted to be in the first place.

To achieve better working conditions for themselves and improve care for patients, job actions are seen and increasingly approved as last resort strategies, 'as long as the patients are cared for'. The need for concerted actions is recognized at some level by all; however, there are currently many barriers that reinforce divisions within the discipline and are in the way of professionalization. The existing historical hierarchies that split nurses seem further reinforced in the current climate. First of all the increasing casualization is in the way of a stable community amongst staff nurses, as discussed in chapter five. Then there is the establishment of further divisions, as specialized nursing jobs, such as nurse practitioner positions, are considered 'advanced practice', while the majority of jobs remain ill-defined. The split between diploma and degree preparation seems to pit classroom learning and experience against each other as a measure of value. Many experienced nurses are turning against students and new nurses, for fear of losing their own status within the hierarchy, thereby co-creating nursing's continuing devalued position. They are often unaware how they themselves are reinforcing the traditional roles of nursing, oppress their own colleagues and even dislike to share their knowledge with patients at times. They also often continue to wait for others to 'take over' and fix things for them, as they see themselves in a 'victim' position.

Much that is taken-for-granted and remains invisible needs to be uncovered to raise awareness and expand the 'field of possibilities' for change. Foucault (1982) talked about the shaping of individuals as 'government', carried out through an 'ensemble of strategies'. In the discipline of nursing it takes place within institutions of education and work. Foucault described socialization processes as individualizing, as well as totalizing practices, robbing subjects first of their old identity and then reshaping them in a desired form and tying them to a new identity. Even though nurses start out, as caring individuals, to help patients, they seem to become

accustomed to serving institutions and other professionals. Perhaps, as several participants suggest, valuing diversities and their various contributions and rallying around a collective vision, compatible with their own personal philosophies, could become effective strategies to stay with their earlier ideals. Thereby they could create counter discourses around common goals such as we 'all want to help patients'. Sawicki (1980) too believes in coalition building across diversities. And Ashley (1997) envisions a 'community of sharing and caring'. United nurses could become the key players who make a difference in healthcare for the quality of patients' lives. The resulting job satisfaction would simultaneously improve their own work lives.

## CHAPTER 8

### CONCLUSION: WHAT DOES IT MEAN? SOME IMPLICATIONS FOR THE FUTURE

#### Introduction

At this point I want to summarize the highlights of the various chapters and tie together the themes that emerge throughout this project. Reflecting back on the literature and findings, and using Foucault's ideas as a guide, I will try to draw conclusions that shed light on nursing's current situation and future choices. Within today's 'field of possibilities' how can nursing be (re) valued and envisioned differently? How can we show the importance of caring? What needs to happen for nurses to bring about changes that allow for 'ethical practices of the self'? In the prevalent discourses on budgets and efficiency, health is seen as a commodity. Healthcare workers, and even patients, seemingly are inserted into predetermined slots to fit the system and expected to produce desired 'outcomes'. Societies seem to head relentlessly towards the 'bottom-line approach' and bureaucratization in healthcare (Davies, 1995; Greenspun, 2000; Gustafson, 2000).

Therefore I will discuss implications that arise from my research for nurses themselves, their practices and relationships with their patients, physicians and other members of the interdisciplinary team they work with, and particularly with each other. What roles are possible for nurses in the future? How can their important contributions to healthcare and their patients' quality of life become more visible and best be utilized? What are the messages for employers and administrators, regarding recruitment and retention of nurses? What are the implications for nursing education -- how can we, as educators, facilitate the development of the caring, knowledgeable individuals that my participants envision as the ideal nurses they would like and could be? And lastly, which areas should be explored by further research? As similar restructuring seems to take place in other sections of public services, such as social work (Chambon, 1999), and education (Acker, 1999a;b; Dehli, 1995; 1996), these groups, too, can probably glean some insights from the findings. Nursing's issues are also closely linked with women's issues, as we have seen. Therefore some aspects of the study might be informative for women workers in general.

### Summary of the Thesis

In chapter one I state the area of concern the thesis deals with, namely the impact of restructuring on nurses' work. It contains an overview of the current situation in healthcare in general, and of bedside nurses in hospitals, in particular. Caring is increasingly defined as a 'string of tasks'; lay-offs and burn-out amongst nurses are rampant. Many leave nursing altogether, while the quality of healthcare deteriorates. This phenomenon leads to the research questions on which the project is based. What does the restructuring process look like at the bedside where it is transformed into actions? How do the changes impact on nurses' perceptions of themselves and the quality of their work lives? What are the nurses' perceptions of their own roles and of the relationships that they have with others in the system? How do nurses themselves participate, knowingly / unknowingly, in the relations of power that bring about restructuring and shape their positions? What are the discourses behind the processes that reorganize institutional work and relationships? How do they impact on nurses' subjectivities and work lives? What are the participants' ideals of nursing? Which changes are accepted and embraced? Which ones are resisted and how? What strategies could be used to (re)value nursing? How could the nurses actively participate in bringing about changes that promote their patients' quality of life and their own quality of work life? I attempted to answer these questions throughout the thesis, particularly in the three 'findings' chapters. I began with the assumption that the nurses' perceptions are important. As frontline workers at the bedside, they have an inside view on how the changes actually play out, as they bear the brunt of their effects.

According to Foucault (1982; 1980), all discourses form an intricately complex network with all other neighbouring discourses, past and present. To better understand the present the past, in which these discourses originated, needs to be revisited. Therefore in chapter two I begin with the historical context in which nursing as a discipline developed. The origins of professions are examined, particularly how medicine, as a classical profession, moved from a status group towards a well-reimbursed and highly respected social class. The barriers for women and their professional projects in general, and nurses in particular, such as their lack of legal and independent social status at the time when modern nursing became established, are discussed. Comparisons are drawn between medicine and nursing regarding their past developments, which

are closely intertwined through complex power relationships. Following the historical review contemporary nursing's realities and trends are discussed. Current thoughts on professionalism are examined and alternative visions based in some contemporary feminist views explored (Ashley, 1997; Daly, 1990; Davies, 1995; Falk Rafael, 1996; Rich, 2001; Sawicki, 1988; Spivack, 1993).

Chapter three deals at length with the conceptual framework. I describe the concepts of power and subjectivity from a Foucauldian perspective: how power works hand in hand with resistance, its strategies and connections to subjectivities. Self government as the main contemporary mechanism of 'governmentality' and the roles 'professionals' play are explored. The function of discourses, representing 'what counts as true' and containing the 'assembly of rules' through which power works, is discussed. The chapter ends with a look at some contemporary discourses of 'managed care', rooted in managerial science and concerned with the 'bottom line' and 'efficiency'. These discourses, despite appearing antithetical to the goal of 'quality of care', increasingly invade healthcare and replace professional disciplinary knowledge in directing its course. Many nurse leaders (see literature review by Smith, 1998) seem to buy into them. They hope to promote their own and nursing's status through an ability to reconcile these divergent goals. Others, however, myself included, are sceptical that this could be achieved.

In chapter four I discuss the methodology of the research. The project's purpose is to explore the nurses' perceptions of nursing in the context of restructuring, as they describe their work experiences. A Foucauldian method demands a close examination of everyday practices and their analysis in light of 'veridical and counter discourses' (Chambon, 1999). Therefore a qualitative, descriptive-interpretive approach was chosen for the study. I first describe the original design, the ethical process and considerations to ensure anonymity for participants, site selection and recruitment. A comparison was to be made between similar areas in two different hospitals: One uses a common humanitarian philosophy based in a nursing theory; the other adheres to general broad guidelines of the College of Nurses but leaves it up to each staff member from which philosophy they want to practice. One of my goals was to determine if a cohesive institutional philosophy makes a difference in the nurses' practice. Five participants

shared their ideas about working with the patient-focused care philosophy.

As no other participants came forward, some modifications of my approach became necessary. There were concerns of being identified in the restricted space of two settings. As further lay-offs were looming potential participants feared retribution, on part of management, for unfavourable comments they might make, an indication of the atmosphere of fear restructuring had created. At this point I began recruiting from all areas of any hospital city-wide; the only condition was that participants were bedside nurses. This strategy proved very successful and the process is described as the journey. To get a comprehensive variety of viewpoints I then used theoretical sampling methods. An ethnographic profile of the participants is also provided. At the end of the chapter I describe the process of data analysis in which findings are organized into three layers, representing three chapters, five, six and seven. Throughout the chapter I try to create an 'audit trail' for others to follow my reasoning.

Chapter five describes the first layer. It is the most superficial one and shows the picture of restructuring at the bedside from the participants' viewpoints. Their thoughts and feelings on this process are reported and then discussed. Several major themes emerge and later carry through all three layers. The most prominent ones are 'lack of voice', 'sitting on the sidelines' and 'not being heard and understood'. The participants perceive changes as imposed from above by others with no knowledge about their work, while they themselves were not consulted. They feel they lack respect and recognition, particularly from their own superiors. They complain of high workloads and 'not enough time to be with patients'. Their knowledge and skills are underutilized while much of their time is spent on 'menial tasks and clerical work' that could be performed cheaper by other workers. Scheduling has become much more inflexible than before, which impacts on their personal lives, particularly of those who are trying to advance their education. There are some positive changes, such as closer collaboration with other members of the health team and involvement in committees and policy making. However mostly it is felt that the quality of care and working conditions have markedly deteriorated.

With casualization continuity of care and stable teams have disappeared. The most extreme example of the resulting 'just-in-time nursing' care delivery (Gustafson, 2000) is employment through city-wide agencies. To remain profitable they charge hospitals way above

the salaries that their nurses receive. Staffing patterns have changed from working together and providing primary care for the same patients throughout their stay towards 'total patient care'. This means that nurses work in relative isolation from each other caring for certain patients during their shift, yet assignments might be entirely different the next day. Some places have nurses teaming up with lesser skilled workers, who do the hands on care, while nurses act as 'case managers', coordinating their patients' treatments and themselves performing only the highly skilled procedures on the run. This arrangement leaves no time for them to get to know their patients. Even families' help is sometimes engaged inappropriately, endangering safe care for critically ill patients. Control over nursing is perceived to have shifted towards management based on a 'business approach'. Many nurses leave the discipline and burn-out is rampant among the ones who stay. Nursing is said to be seen as 'just a job' by many. How the participants believe restructuring should be carried out to improve current situations is summarized below:

- More input by the bedside nurses in reorganization of work environments and where and how cuts could be / should be made.
- Decreased workloads.
- Nursing education with more focus on practical bedside experience and longer orientation sessions for newly hired nurses.
- More recognition and support by management for nurses.
- Input by nurses into their scheduling, more flexible working hours.
- More continuity in assignments, hands on patient care, return to primary and team nursing with stable staffing patterns.
- More support staff for menial tasks, especially clerical work.
- Overall: hire more full-time staff, pay them well, educate them well and treat them well.

Chapter six looks into the 'strategies of power', how power works through relationships. In this second layer the focus is on power's mechanisms and the underlying discourses, how nurses, knowingly and unknowingly, perceive and negotiate their roles with others: their patients, other nurses, members of the multi-disciplinary team and administrators. The nurse-patient relationship remains at the heart of nursing, as participants all derive their greatest job



satisfaction from being able to help others. Often nurses will go out of their way to give good care to patients. Yet due to increased stress and workloads the quality even of these relationships begins to wear thin in some places. Scared and dissatisfied patients often get angry at the nurse, who appears as the 'immediate enemy'. As nurses highly value recognition from patients for their work, being criticized adds to their disillusionment. How nurses relate with each other, as well as their own inegalitarian relationships within the nursing hierarchies, also comes to light. They use various mechanisms of power, such as siding with physicians against colleagues, vying for approval by those thought to be more powerful, withholding of knowledge from other nurses and bullying practices within their own hierarchies. The latter are directed particularly towards those new to the discipline and new to a particular work place, where established rank systems are maintained.

Traditions that seem to give licence to certain categories of nurses to tell others what to do exist and are taken-for-granted. As these 'dividing practices' (Foucault, 1982) have become 'naturalized' they are not readily noticed. Although these mechanisms have been in place since nursing was established as an organized discipline, they seem even more exacerbated as casualization isolates nurses from each other. If they are recognized they often are rationalized as 'specific to women'. How focusing on one discourse can easily lead to blindness towards other issues is demonstrated in Nestel's (2000) examination of midwifery, discussed earlier. Yet there is also increasing awareness. Amidst the turmoil restructuring created, at least some of the participants seem to realize that these practices are self defeating and most clamour for more collegial, kinder relationships. In some areas nurses are beginning actively to support each other, realizing that they need to help themselves, as no one else will 'do it for them' and that there is 'strength in numbers'. They discover it to be a rewarding experience. A new-found solidarity is also evident in the recent job actions that took place in unprecedented numbers in several provinces over the last few years. Despite the multi-cultural group of participants differences arising from race or ethnicity did not become evident; perhaps this was due to the focus on restructuring versus other issues.

Increasing inter-disciplinary team work has improved relationships amongst the team members as they gain a better understanding of each others' roles. Their collaboration facilitates

caring for patients. Yet, the downside is, nurses often tend to go along with the team's decisions without contributing the unique insights gained from their sustained interactions with their patients. Perhaps lacking confidence to speak up, and doubting the importance of their contributions, they miss opportunities to take on an unique role as representatives of patients and their families, whose well-being is their professed *raison d'être*.

Historically sanctioned 'veridical' discourses and traditions of nurses supporting physicians and their work continue to impact on nurses' practices -- largely taken-for-granted and therefore invisible to them. By examining their stories and comments they come into sharper relief, particularly the ongoing facilitation of physicians' work, while their own achievements remain in the shadows. Doctors still meddle without official authorization into nursing's affairs, such as hiring, lay-offs and wages. Nursing practice, even today, is widely assumed to be subordinate to this group' work by many outside of nursing. Bio-medical knowledge remains the 'veridical discourse' (Foucault, 1982) often to the exclusion of other types of knowledge and healing practices. Nurses' practice of 'caring', on the other hand, is still poorly understood and, as nurses lack 'voice', remains unproclaimed. Administrators are thought to be orchestrators of restructuring 'in an office somewhere' and to make the major decisions that impact on nurses' working conditions. As the top administrators are largely unknown and operate in mystifying anonymity, the unit managers are the ones the nurses interact with. The participants strongly criticize those unit managers who they perceive as focused primarily on 'managing' instead of supporting their staff. This is particularly evident when the manager is from another discipline and therefore lacks the knowledge background to understand nurses' experiences and work.

In chapter seven, the deepest layer, the nurses' subjectivities, how they perceive themselves and are perceived by others, are explored. Nurses' identities have been shaped against those of physicians and others and their perceptions and actions have been normalized within traditional discourses of the discipline. These traditional discourses are also embedded in the complex network of neighbouring practices, such as discourses on women, the bureaucratic system and society in general, that portray their identities in specific ways. Participants reflect on their ideals and philosophies of nursing, their conceptualizations of how they want to be and practice. They value both education and experience. They also treasure close relationships and

interactions with their patients; yet increasingly they are reduced to managing others who do the hands-on care and to perform highly skilled tasks on the run, which leads to 'the polomint problem' (Davies, 1995). The ideal of nursing is expressed as 'being there for patients' and treating them as they would like themselves or their families to be treated. Campbell's (1992) assertion that bureaucratization is alien to nurses' own perceptions of their work is thereby confirmed. How individual participants see nursing also articulates with other discourses, such as Christian religion, nursing theories and the holistic health movement. The nurses familiar with patient-focused care all agreed with its philosophy, and would themselves like to be treated in this way.

Yet, as seen in the previous chapter, when given the opportunity to represent patients' views and wishes, they often go along with the inter-disciplinary team instead, lacking the confidence and will to speak up. Nurses are sometimes reluctant to share information with families and patients, afraid that these groups might 'abuse their power' when given 'too much knowledge'. They admit that it is hard not to tell patients what is best for them and to respect their choices instead. Holding on to the 'expert' knowledge mystifies nurses' roles and creates an inegalitarian relationship with patients and families that ironically is in keeping with the traditional concepts of professionalism. The philosophy of patient-focused care holds the potential for those that understand and work with it to gain insight into their own power strategies. Once aware, they can develop ways to practice ethically within their unavoidably inegalitarian relationships, with 'a minimum of domination'.

Ideal nurses not only care for patients but also for colleagues and, as some participants add, for themselves. They value self-confidence and open communication with each other. They are beginning to see the necessity to advocate for themselves as nurses, as they slowly recognize that they themselves are trapped in a web of unequal power relationships with others in the system, who 'impose on them'. The participants almost unanimously support the Quebec nurses who at the time are taking job actions and approve of striking as a 'last resort, as long as patients are cared for'. In this section the struggle of 'old' and 'new' subjectivities is evident, from 'being there for others' to 'asking for themselves', as individual nurses take them up and inhabit them in heterogeneous positions. They also talk about other collective strategies, such as media

campaigns to 'make themselves heard'. In regards to professionalization their perceptions are divided. Some uncritically see themselves as professionals, others believe nurses are on the way to becoming professionals, and a few vehemently deny that nursing is a profession, mostly due to how others treat them. The degree requirement as entry to practice, which is also a professional requisite, surprisingly is largely welcomed. Even older diploma trained nurses, many of whom are said to 'eat their young', especially new 'degree grads', admit that a liberal education will instill nurses with self-confidence. It is hoped that higher education will elevate nursing in the eyes of others. At the same time the limitations of this strategy are also recognized: there are some doubts that doctors will respect nurses more because of it. It also 'will not fix nursing's problems' -- nurses need to 'stand up for themselves' and 'make themselves heard'. The degree requirement is simultaneously perceived as further dividing nurses and playing those with and without degrees against each other, as a need for more unity is recognized. Hospital managements also are suspected of exploiting the situation by redescribing jobs, laying off experienced nurses high on the pay-scale, and replacing them with brand-new graduates on low salaries.

As Foucault (1982) predicted, at the 'local level' the points of resistance, and therefore also the possibilities for change, are found where nurses have insights into their exploitation, domination and subjection. The nurses object to strategies of domination, how restructuring was 'imposed from above' on them by those lacking knowledge of the bedside, without their involvements. Similarly they resist how the mandatory degree requirement was also introduced 'from above by the nursing elite'. Although it was an act of benevolent intention, it thereby became a 'totalizing' practice. They are particularly angry about the concurrent devaluation of experience that went along with it. As there is lack of recognition for their work, they see themselves as taken-for-granted -- 'doing good, feeling bad' (Acker, 1999a;b). All maintain that nursing, as a practice discipline, can not be learned in the class room alone, it needs to be experienced at the bedside. Yet not only experience is devalued. They all feel that their knowledge and skills are underutilized, as more routinization is increasingly introduced. Much of the knowledge gained in university, such as communication skills, can currently not be applied in most settings, due to unreasonable workloads. Establishing relationships takes time, which they

do not have. This brings into question why a degree is required amidst 'deskilling' and routinization, showing how contradictory discourses are transforming the workplace simultaneously. And lastly they are forced into roles they 'do not want to be' (Foucault, 1982), such as 'case managers' and 'task providers', instead of 'caring' bedside nurses. Their ethical practice is interfered with.

The major themes surface in chapter five and then, like leitmotifs, can be followed through six and seven. They are about 'not being heard', not 'feeling understood' and not 'being appreciated'. Nurses see themselves as marginalized, without input into any of the changes brought about by restructuring. They are left with 'not enough time' and 'no continuity' in caring for their patients, to do their job as they would like to, which interferes with their 'self-styling', how they want to practice as moral subjects. A lack of respect pervades the system, not only 'receiving but also giving' it. The data lead to a multiplicity of current discourses sustaining the relationships of power in healthcare which can be better understood by looking 'through the window' of nursing's past (Chambon, 1999).

### **Lack of Voice and Respect, Feeling Marginalized**

Looking back towards nursing's historical development the lack of voice is nothing new. Nurses, as women, held no legal status at the time of Nightingale. At that time, when nursing emerged as an organized discipline, women could not hold public office. Their silence and support of professional men from behind the scenes was demanded and rewarded. Medicine appropriated the hegemonic discourse of the 'natural sciences', which is exemplary of the positivist paradigm and research methods. Its goal is to conquer disease by finding cures and eventually eliminating death. The caring discourse pales in comparison, as its promises are much less dramatic, such as connectedness, support and quality of life for those stricken with illness, aiding in their 'healing'. Women's nurturing and caring role is also something that is expected, but not appreciated. Seen as a 'natural ability' the hard work that goes into it is not valued (Adkins & Lury, 1999; Davies, 1995; Farrell, 2000). Performing this role makes women feel unsatisfied (Acker, 1999a). From a Foucauldian perspective women's social roles arise out of a 'regime of truth' consisting of scientific categorization (the 'weaker sex', caring as natural to

women) and 'dividing practices' (emphasis on biological differences from men), leading to a distinction in society's members, dependent on the concept of gender. These gendered designations emerged over time, but are also constantly in flux as they transform through complex 'agonisms as well as antagonisms of strategies' with all 'the neighbouring discourses, past and present' (Foucault, 1980, 1982).

As was described earlier, nurses as members of a female discipline unable to establish full professionalism, became subordinate to medicine and hospital administrators, within their own hierarchical structures. Through lack of legal and social status, they were regulated from the outside, followed orders, and their labour easily exploited, as self sacrifice was constructed as a feminine virtue. Their training was obtained largely through an apprenticeship mode. While physicians gained respect, nurses increasingly lost it. Nightingale's dream had been to start an honourable profession for women to provide them with an appropriate medium to channel their energies and make valuable contributions to society. Yet, particularly in North America where schools lacked endowments, nursing students were forced to sell their services to hospitals in exchange for training. With the institutionalization of healthcare, graduate nurses too had no longer a choice but to work for hospitals instead of directly for patients in their homes.

Resistance, in the form of a call for nursing instruction in formal educational settings outside of hospital schools, was evident early on. Yet only in the 1970s was there a widespread move into colleges and universities. In Canada the Weir report had recommended a university education as early as 1932. A degree requirement as entry to practice will finally be in place in the year 2005. However, it has to be remembered that this call originated from the nursing leadership. It had been imposed upon the marginalized rank and file nurses, who felt it was brought in at the cost of devaluation of experience. Divisions within nursing had always existed, from the matrons at Nightingale's time presiding over the bedside nurses to other groups with special status, such as public health nurses in Ontario early in the last century, vis a vis their hospital colleagues (Stuart, 1999), as nurses live within their established hierarchies.

My data seem to support that nursing actions remain largely invisible to the public and subsumed under medicine. What the media report on is labour issues, such as nursing shortages and strikes. Amongst themselves nurses often show little respect towards each other, as whatever

power they exercise 'comes at a cost' (Foucault, 1982), frequently paid by their own colleagues. Nurses in leadership positions, such as management, mostly impose on bedside nurses. By seldom consulting the ones who are most affected by these decisions, they carry on historical traditions. In the literature we see an unconditional acceptance by many nurse leaders of the value of medical knowledge. Many continue to try emulating physicians' successes (Beletz, 1990; Molony, 1992). Lately there is widespread adoption of managerial science as a new 'veridical discourse' (see Smith, 1988). Creating specialized roles for a few, such as nurse practitioners, is considered more desirable than the elevation of all nurses' roles by valuing 'caring'. Within their own ranks, established nurses versus new nurses, experienced nurses versus newly graduated nurses, and diploma nurses versus degree nurses, all use strategies of power that strive for an advantaged position within unequal relationships. These 'antagonisms of strategies' amongst themselves prevent effective and concerted actions.

It seems that none of the current strategies of power is new, but they all build on historical mechanisms. As Foucault predicted, by simultaneously reinforcing and exacerbating the already existing relationships among the players, these same mechanisms seem to have created the very conditions that made restructuring possible, in the way it happened. The conditions themselves thereby simultaneously got further reinforced in a vicious cycle. How some of these discourses get negotiated within the nurses' own consciousness and influence how the nurses wish to practice -- their relationships with themselves -- have been glimpsed in the participants' comments and stories.

However, amidst the seeming continuities there are also discontinuities. Power, as a positive, productive force has created new opportunities. Whereas many nurses still see themselves as 'passive victims' and wait for others to 'fix their problems', there is also more active resistance today than in the past, as the widespread recent job actions attest to. That almost all my participants agreed that striking is sometimes necessary, seems surprising, as six years earlier the attitudes amongst a sample of staff nurses had been much less favourable towards this option. Another difference is that nurses leave nursing in droves. The ensuing nursing shortage has led to an unprecedented turn-about -- nurses are now being wooed to return to Canada from the U. S. with bonuses and full-time positions (Sharkee, 2001; Mackimmon, 2001). Alberta nurses

settled recently with a 42% pay hike as they negotiated their contracts and other provinces, including Ontario, are in the midst of bargaining right now. Grinspun (2001) talks about recent political involvement and progress that nurses have made at the level of their professional association, allowing them more input into their own affairs, such as through the appointment of a Chief Nursing Officer to Ontario, increased funding for recruitment and retention, as well as educational assistance and a stronger advisory role with the government on policy making. It seems that nurses finally are beginning to be 'listened to'.

### **Limitations of the Study**

This study represents a snapshot of a particular timespan over approximately seven months during the restructuring process taking place in a major city in Ontario. There is no claim that the twenty participants are representative of nurses in general or that restructuring had the same impacts and manifestations elsewhere. While looking for a variety of viewpoints, I realize that these voluntary participants represent a 'biased sample' in their commitment to nursing, as is evident from their levels of education and number of specialty courses they had taken. Of course, by no means, are they representative of all other nurses and their viewpoints. Their perceptions were enlightening about what went on at the bedside within the temporal and geographical confines where the study was carried out. Some of the underlying discourses that shape subjectivities and actions were glimpsed from their tales and comments. The data obtained can not claim to be accurate interpretations of the events themselves and are by no means exhaustive. Negative comments about nursing practices were made in relation to 'other' nurses and/or the participants' own experiences as 'victims'.

Amongst nurses many other viewpoints exist, possibly as many as there are members of the discipline and only some of them are represented here. Although personal beliefs and religion were mentioned as guiding practices, some issues that did not come into focus in this study relate to how 'race' and 'cultures' affect nursing. Even though my participants represent a variety of ethnic and racial backgrounds, differences due to cultural diversities did not surface. 'Class' came up once when one participant reported that she was 'channelled' into nursing by her teachers. As she was 'from a lower class and would never amount to much of anything' nursing



was thought to be the appropriate choice. Yet this aspect was not pursued with other participants, as it was not the focus of the research. As restructuring was mainly a labour issue, revolving around job security, staffing, seniority, workplace environment and workloads these areas were in the foreground. A second reason is that the interview questions I asked were focused on restructuring's effects and hence not conducive to reflections on 'dividing practices' that did not appear to be directly related to this phenomenon. In the next sections I will try to draw some conclusions from what we have learned.

### **Nurses' Future Roles and 'Professionalism'**

The biggest issue for nurses seems to revolve around increasing mutual respect and cohesiveness. I believe it is extremely important that efforts should be directed everywhere to care not only for patients but also for colleagues. A reconceptualization of nursing should start with 'reflective practice' (Davies, 1995). As they think about it the participants seem to recognize that mutual support is beneficial. Perhaps nurses themselves can begin learning to appreciate each other as humans, by unlearning the stereotypes they hold, and then to look towards what they could become. Stuart (1999) shows the human side in some of the nurses who went to the first World War. Even though the ads of the day portrayed them as "the self-denying 'mothers of the world' who would save it from the barbarism of war" (p.171), their decisions going to war were often made for other than patriotic reasons. Frequently "good times rather than the horrors" were revealed. Many went for adventure, travel, perhaps to escape the boredom of conventional marriage, to find a socially acceptable single life and a new career in the well-respected field of public health nursing upon their return.

Frey (2001) and Buresch and Gordon (2000) encourage nurses to 'find their own voice' and learn how to speak about what they are doing, to make nursing 'visible'. Buresch and Gordon (2000) talk about the differences between physicians and nurses when they inform the public about their work: Nurses tend to submerge their 'I' into the 'we' of the health care team, to the point of giving credit to others, particularly physicians, while obscuring their own contributions. Physicians, on the other hand, often can not find the 'we' in the 'I', as they fail to acknowledge others' input. They tend to portray their own efforts as solely responsible for patient

survival and recovery. The authors point out further that nurses feel often what they do is too ordinary, as it lacks the high drama of medicine that the media feed on. Yet it is in these acts of human connectedness that healing takes place. As Watson (1985) maintains, 'there can be caring without curing, but there can be no curing without caring'. Nurses therefore must learn to conceptualize and articulate nursing more clearly in order to create a counter discourse that is heard. Once they see their work as important they can learn to appreciate and support each other.

They further could refuse to support other professionals through 'ordered caring' (Falk-Rafael, 1996), such as chasing physicians, and thereby wasting their own and the patients' time. They could refuse to do menial tasks, and support colleagues who wish to do so, instead of sabotaging them. Holding loyalty to patients as their first priority, based in nursing knowledge and research, they could focus on promoting their well-being and representing their wishes with the rest of the team. Their relationships with patients is after all the 'heart and soul of nursing', as these and other data I collected show (Daiski, 1994; 1997). They also could form powerful alliances with the public who seem increasingly to grow disenchanted with the deterioration of quality in healthcare. By sharing knowledge with them they could practice 'empowered caring' (Falk-Rafael, 1996), simultaneously also helping to empower others. A counter-discourse could be created, based in a common vision and philosophy. Its goal could be a 'community of sharing and caring' (Ashley, 1997) that is capable of challenging the current 'corporate managed care approach' (Padgett, 1998).

### **Implications for Recruitment and Retention**

For employers and managers it might be more cost effective, when restructuring, to ask nurses who are the experts at the bedside about their input and avoid costly mistakes. They might want to sit down and discuss the recommendations of their staff with them. Happier employees might take less sick time, be more productive and more loyal to an institution where a collaborative atmosphere exists. Cronin and Becherer (1999) suggest unit managers to provide positive feedback for work well done. My participants had stated that support for and appreciation of their work was very important to them; yet many of their unit managers were seen as unjustly critical and disrespectful of nurses. Del Buono (1993) also recommends to build a

stable work force not just filling positions for the short-term. Otherwise frustrated nurses will leave hospitals for other areas of work or see nursing as 'just a job'. Longer orientation times and staff mixes of new and experienced nurses will facilitate better care and decrease stress. Carey and Campbell (1994) place high value on preceptorship and mentorship of new nurses, particularly through role modelling and emotional support. Working together in stable teams should also increase staff morale and provide better patient outcomes.

More full-time employment, flexibility in scheduling, particularly for the purpose of education, will also benefit employers, as well as patients, in the long run. Cooney (1994) found that productivity of experienced and happy staff is definitely higher than that of part-time employees. Irvine, Sidani, and McGillis Hall (1988) link good nursing care to shorter hospital stays of patients, which will decrease expenditures in the system. Currently McMaster University in Hamilton conducts a research project on Nursing Effectiveness, Utilization and Outcomes (Picard, 2001, June, 20, p. A3). Picard highlights recommendations of the research, such as continuity of care, more full-time employment and overall better working conditions, that should be tied to accreditation of hospitals. Scott, Sochalski and Aiken (1999) advocate for collaboration and decision making with staff. With better working conditions there might be previously untapped resources, when nurses can actually apply all the knowledge and skills they have acquired, through education as well as experience. I would add, most importantly, that at the unit levels nurses should be consulted, in particular about which tasks can be performed safely by lesser skilled workers and which ones they need to do themselves. Bringing back flexible scheduling is another key issue in reducing burn-out and sick time.

### **Implications for Nursing Education**

A liberal education seems to be appreciated by the nurses, and the degree preparation is thought of as an approved avenue to take. Confidence building instead of only information building is an important goal (McGregor, 1996), such as by adopting a 'caring curriculum' (Bevis & Watson, 1989). Most importantly experience should not be devalued at the cost of classroom learning. Nurses want and need hands-on experience during education and orientation to new work environments, as in a practice discipline experiential learning is essential. They also

need help with integrating the theoretical knowledge into practice, due to the complexity of human beings and their conditions, for many years. Learning about nursing's own body of knowledge and nursing's historical roots and current context from critical perspectives holds the potential for nurses to become aware of everyday taken-for-granted practices and to expand their 'fields of possibilities' in how it could be different and better for their patients and themselves. Thereby learning can become a transformative and emancipatory experience.

Like Buresch and Gordon (2000) I think that nurses should share their stories, particularly to demonstrate application of theories to practice in order to narrow the 'theory-practice' gap. Students could be encouraged to publish well-written essays, in which they relate their practice experiences to theoretical nursing knowledge, for other nurses to benefit and learn. Farrell (2000) discusses how dominant discourses can be taken up by educators in various ways. Quality management, for example, can refer to following care maps accurately or to providing excellent care for patients according to their needs. Within the dominant discourses 'new spaces of freedom' can always also be found. Lastly, striving for professionalism we should provide our future practitioners with options to carefully think about what this profession should look like. Do we, as a community, want the traditional model with its 'elitist structure and knowledge shrouded in secrecy and guarded jealously' (Woolf, 1938)? Or do we want a 'community of sharing and caring' (Ashley, 1997), of connectedness and concern for each other as well as the eco-system (Daly, 1970/1990; Rich, 2001), a model of 'empowered caring' (Falk-Rafael, 1996)?

### **Implications for Further Research**

Further research efforts should be directed towards making caring and its benefits to patients visible, thereby helping others, as well as nurses themselves, to value nursing. Qualitative approaches need to become more recognized to show nursing's benefits, through patients' stories, nurses' stories (Buresch & Gordon, 2000). They also need to be linked to quantitative criteria such as shortened hospital stays, decreased readmissions and better health requiring fewer services. Some studies should particularly explore whether nurses' input into restructuring could make it more cost effective. Further research, similar to the studies of Carey and Campbell (1994), Cooney (1994), Cronin and Becherer (1999), Del Buono (1993), Irvine et

al. (1988) and Scott, Sochalski and Aiken (1999), as well as this thesis, could support relations between job security / satisfaction and recruitment / retention of nurses and better patient outcomes.

Other areas that need further exploration are the nurses' relationships with each other, other health professionals and their patients. Nurses need to gain more insight into their own power practices, to become aware of 'how they do not want to be'. It should be further explored how the circulating discourses that form subjectivities through these everyday practices can be made more visible. Ways should be found to show how things could be different -- how things are is always 'exceptional' -- by expanding the 'field of possibilities' (Foucault, 1982).

### **Concluding Musings**

My data were collected between the end of 1998 and summer of 1999. Now about two years later the nursing shortage has become severe. Nurses are currently negotiating in several provinces, including Ontario, for a new settlement. They are also 'working to rule', meaning they are now taking their due breaks, finally, and refusing overtime, as negotiations keep breaking off. They recently settled in Alberta with a much publicized pay increase. In Nova Scotia nurses currently take job actions, while the government is bringing in legislation to take away the right to strike for healthcare workers. As usually the focus of the media is on wage issues, not working conditions. Here at home, from what my students tell me, employers still demand that nurses work in casual positions for more than one unit, few are hired full-time. Some nurses, especially those in specialized units, are leaving to work for agencies, which have lots of assignments for them at the moment, due to high demand. Through this move the nurses see their salaries take a big increase, while as 'agency nurses' their responsibilities are fewer, and they gain control over their schedules. Yet, there is also a danger in this strategy. As they are no longer protected by their unions, in the long run when supply of nurses again exceeds demand, they could see their wages and work opportunities plummet. Stress levels in hospitals are as high as ever and staff sickness is rampant, particularly due to back injuries from heavy lifting. Hospital representatives still complain they are underfunded. Recently the CEO of a major institution warned of impending staff lay-offs, including those of nurses, to stay within the limits of the budget. It

seems very little has changed.

On a more positive note, patient-focused care is piloted in several institutions across the province under the auspices of the College of Nurses. It is important, I believe, to differentiate the patient-as-expert of his/her own life from the patient-as-expert in management of the disease process itself. Whereas the former discourse tries to render the nurse-patient relationship more equitable, the latter discourse supports the ongoing devolvement of responsibility for services to patients and their families within the current neo-liberal agenda. In two of the hospitals from which I had recruited participants, regular meetings are now being held between nurses in higher administration and staff. Bedside nurses are invited to share their concerns and ideas -- a good start. A letter to the editor (Jack & McLean, 2001, p.5) of the latest Communique reports on a day-long workshop (with pay!) during which the staff nurses were consulted on how to promote excellence of care in their setting. The response is reported as 'remarkable'. In addition many nurses on duty that day, who could not attend, participated through a survey. In the same issue of the Communique (Macleod, 2001, p.4) I learn that a new diploma nursing program is in the making -- the RPN of the future will have at least four semesters of Community College preparation, starting in 2005 when RNs will graduate with a baccalaureate degree. Perhaps it was recognized that there is a 'niche' for a diploma nurse, after all, while a new layer of degree-prepared nurses was added into the nursing hierarchy. The danger is that training of this new diploma nurse could focus on the purely 'technical' to provide care as a 'string of tasks' in keeping with the 'managed care framework'. The university-educated Registered Nurse at the bedside, on the other hand, has the potential to elevate the discipline into becoming more knowledge-based, and could add a 'counter discourse' of 'reskilling'.

As some of my participants have started to realize, nurses need to think about their common goals, such as wanting to 'help people', and then develop a common vision around which they can rally and which aims for a 'minimum of domination' of others, colleagues and patients. With the shortage of nurses right now perhaps some 'spaces of freedom' (Foucault, 1982) have opened up. The time might be right to squeeze into them.

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## Appendix A

### Covering letter:

#### **Bedside Nurses' Perceptions of Nursing in the Climate of Restructuring**

Dear Ms./Sir,

The purpose of my project is to learn about the impact the current restructuring of the healthcare system has on the bedside, and how it affects the people involved. I believe it is important to hear from nurses, who are on the frontline, what it is like to work within the present environment. What are your experiences and the thoughts you have in this regard? From your place at the bedside, what are the effects of the changes in the healthcare system on you and your work? Please remember there are no right answers. But, to find better answers, your voices need to be heard and included.

If you would like to participate we will discuss this topic at your convenience. I will audiotape our conversation and later transcribe it. This study will become part of my doctoral dissertation. Results will also be discussed at conferences and possibly published. Your identity will be known to me only. To protect your privacy I will keep out real names and all identifying characteristics. You have the right to withdraw from the project at any time, if you wish. Meanwhile feel free to ask me any further questions regarding the study that you may have by contacting me at the numbers, listed below.

Sincerely,

Isolde Daiski, RN, Ed.D. Student

Ontario Institute for Studies in Education, University of Toronto

252 Bloor Street West, Toronto, Ontario, M5S 1V6.

Telephone: (work number and home number)

## Letter of consent

### Title of the Project:

#### **Bedside Nurses' Perceptions of Nursing in the Climate of Restructuring**

I hereby consent to participate in the above named research project. Isolde Daiski will conduct an interview with me, which will be audio-taped and later transcribed by her.

I have read the letter explaining the project and want to discuss my ideas on restructuring in nursing and how I see myself as a nurse. I am also aware that my participation is strictly voluntary and that I can withdraw from the study at any time, if I wish.

---

Participant

---

Researcher

---

Date

## Appendix B

### Interview Guide

#### Part A: Demographics

##### Job related information:

How long have you been a nurse?

How long have you worked within the present institution?

Where did you work before that?

What is your present position?

What is your education: highest level achieved?

Did you take any specialty courses/ certificates in nursing? non-nursing ?

##### Other information:

Age group, gender, cultural/ ethnic/ racial self identification, professional/ occupational memberships.

#### Part B: Interview

##### Restructuring:

##### Main question:

What has your experience been with the current restructuring of the healthcare system? How has it affected you and your work?

##### Prompts:

Talk about advantages.

Talk about disadvantages.

How do you cope with the present situation?



What is your present level of satisfaction with your work?

How do **you** think restructuring should be carried out?

### **Institutional relationships:**

#### **Main question:**

I am interested in your relationships with people you encounter through your work:

First: patients and their families/ friends.

Second: your nursing co-workers/ administration.

Third: doctors/ other disciplines.

#### **Prompts:**

How do you feel they perceive nurses and nursing?

How do they treat you?

### **Perceptions of occupational identity:**

Why did you decide to become a nurse?

Is nursing what you expected it to be or not? Elaborate.

What do you think about it now? E.g. Describe a typical good day and a bad day.

Where do you think nursing should go from here? What do you think of the baccalaureate as entry to practice?

What is your idea of the 'ideal nurse'?

What conditions are necessary to be / stay the nurse you ideally would like to be?

Do you think nursing is a profession? Why/ why not? If not, what is needed?

What about job actions?

Do you have a personal philosophy that guides you in your practice?

#### **For Group 2 only add:**

What is it like to practice from the philosophy of 'patient focused care'?