

# **The Social Construction of Competence and "Incompetence": Problematics of Hospital Nursing Work in the Era of Restructuring**

by

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## ABSTRACT

This is an institutional ethnography of front-line nurses and their work in hospitals in Vancouver and the Lower Mainland during the turmoil and change of health care restructuring. "Restructuring", then, is a contextual theme overshadowing the working lives of the nurses in this study. Another contextual theme is job segregation on the basis of gender and racialized ethnicity, seen when comparing the demographic compositions of nursing working groups on different levels of care (for example, more nurses from formerly colonized countries work in lower prestige areas like extended care).

The intensification of nursing work, routinization, and an increasing division between conceptual and physical tasks have characterized hospital nursing work in the last decade. Nurses' anxiety about being "competent" in this new environment sometimes culminates in dysfunctional processes of negotiating "competent/incompetent" identities. This process (identified in the study as "anxious competence" and "projection of incompetence on the other"), is parallel to the phenomenon of "targeting" or workplace bullying at other worksites, and is usually directed by a few nurses toward an individual nurse who is new to the floor or who is somehow "different". This kind of targeting demarcates for some nurses the boundaries between what is competence and what is incompetence, and helps to maintain the reputation and prestige of their working group as "high functioning". Nurses have developed tactics of solidarity and resistance to targeting and negative effects of restructuring.

The conceptual framework is informed by social constructionism, labour process theory, and feminist critical social theory. Fieldwork consisted of participant observation on three floors (corresponding to critical, acute, and extended levels of care) for one year in two hospitals in the Lower Mainland; and interviews with 25 front-line nurses and four nursing managers. Suggested policy changes could improve the working and interactional environments of nurses.

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## **CHAPTER ONE: INTRODUCTION AND BACKGROUND TO THE PROBLEM**

### **Introduction**

Hospitals in British Columbia and in the rest of Canada have been buffeted by the turmoil and change of health care restructuring<sup>1</sup> for over a decade. "Restructuring" of the health care system has been a process of amalgamating regional health boards and hospitals, downsizing and closing hospitals, relocating programs, and contracting out services to the private sector, in response to governmental policies of "cost containment" in the public service sector. Restructuring started in Vancouver with the closure of a major teaching hospital in 1993, the displacement of its staff, and their relocation to hospitals throughout the Lower Mainland. At that time, head nurses were replaced by "nursing unit managers", and nursing wards became referred to as "cost centers".

Restructuring in health care mirrors similar restructuring activities in major industries and corporations taking place in North America and worldwide for the last two decades. As a result of restructuring, the members of the nursing workforce in hospitals have been facing uncertainty about their own futures, the futures of the hospitals and wards they work in, and the future of nursing itself.

In addition to the backdrop of restructuring, job segregation is another contextual theme embedding the work and interactions of hospital nurses in Vancouver and the

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<sup>1</sup> Although I refer here to restructuring of the health care system as a whole, in the study I focus on restructuring specifically in hospitals.

Lower Mainland. Within the gender-segregated occupation of hospital nursing, nurses appear to be allocated, on the basis of racialized ethnicity<sup>2</sup>, into levels and strata with different degrees of prestige, status, and relative privilege. Relative privilege within the different levels and strata is both reinforced and challenged during interactions on the hospital floors. Thus, a confluence of the attributes of "racialized ethnicity, gender, and class", along with the process of restructuring, helps to shape the interactions, work, and experiences of nurses working in hospitals.

The present study is an examination of the problematics of hospital nursing work and the interactive environments among nurses, amid the changing health care system during restructuring, starting from the perspectives of front-line nurses on hospital floors in Vancouver, British Columbia. The conceptual framework of the study is mainly informed by the theoretical perspectives of social constructionism, Marxist labour process theory, and feminists writing in the critical social theory tradition. The method is guided by "institutional ethnography" (Smith, 1986; 1987; 1992) - a research strategy aimed at discovering the hidden social relations that structure the everyday working lives and experiences of women (or other people), and which begins from their perspectives.

While scholarship into the confluence of "race, class and gender" in diverse academic areas has burgeoned for over a decade (Andersen & Collins, 1995; Banerjee, 1993; Berberoglu, 1994; Bennett, Brewer, & Kuumba, 1999; Brooks, 1989; Chow,

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<sup>2</sup> In academic discourse, the terms "race", "ethnicity", and "colour" are sometimes used interchangeably. Some authors cited in the study refer to "race" when considering the confluence of "race, class, and gender". "Racialization" is another term in common usage, along with "racialized ethnicity". In this study I use two terms to refer to nurses of colour who work in hospitals: "women of colour from formerly colonized countries"; or "members of racialized ethnic minorities".

Wilkinson, & Zinn, 1996; Collins, 1993; Comack & Arat-Koc, 1999; Creese, 1999; Creese & Stasuilis, 1996; Das Gupta, 1994; Harding, 1991; Hemmons, 1996; Higginbotham, 1989; Horowitz, 1991; Hubbard, 1997; Kandal, 1995; Kendall, 1997; Ng, 1994; 2001; Rothenberg, 2000; Satzewich & Wothorspoon, 1993; Schechter, 1998; and Vorst, 1991) it still remains sparse in the health care sector. Research examining the impact of these factors under restructuring is almost non-existent. Some researchers have considered the impact of health care restructuring on nursing work and on the well-being of nurses (for example, Armstrong, Armstrong, Choiniere, Mykhalovsky & White, 1997; Fuller, 2002; Lynam, Henderson, Browne, Smyth, Semeniuk, Blue, Singh, & Anderson, 2003; Rodney, 1997) and others have studied the effects of gender oppression (Hedin, 1986; Roberts, 1983; Thompson, 1987), class (Campbell, 1988, 1992; Glazer, 1991) and racialization (Bryan, Dadzie & Scafe, 1985; Das Gupta, 1996; Calliste, 1996) in hospital nursing, but few have studied the effects of the intersection of these phenomena among members of hospital nursing working groups. In their analysis of nursing as a female segregated occupation, Hedin (1986), Roberts (1983), and Thompson (1987), for example, identify a phenomenon of "horizontal violence" among nurses, which they characterize as "oppressed group behaviour". Bryan, Dadzie and Scafe (1985) examine the segregation of Black nurses in the British health care system, just before restructuring took place there. Calliste (1996) and Das Gupta (1996) document a process of "targeting" aimed at Black nurses in Ontario hospitals, and suggest that this phenomenon has increased during restructuring.

When beginning the present study, I suspected that "targeting" (also known as "workplace bullying" or "mobbing") was a possible pathway through which job

segregation on the basis of racialized ethnicity is maintained in hospitals. The results of the study do suggest that targeting is implicated in job segregation, although it was found to be a far more complex phenomenon than I originally expected, and was found to be directed towards nurses of varying ethnic backgrounds – those of white Anglo European origins as well as those identified with racialized ethnic minorities. As the data collection progressed, most targeting incidents were observed to take place on acute care floors. Working on acute care floors is considered preparatory towards working on more desirable areas such as critical care and other specialties. Targeting on acute care floors, then, or the fear of being targeted there, confers upon the acute care floors a gate-keeping function in the nursing workforce, that prevents some nurses from working there with a view to progressing to other specialties such as critical care. The effects of beliefs among some nurses in the post-colonial present (Kirkham, Smye, Tang, Anderson, Blue, Browne, Coles, Dyck, Henderson, Lynam, Perry, Semeniuk, and Shapera, 2002), about nurses who have different origins in the colonial past, and the role that this may play in generating targeting episodes, are explored in this study.

Targeting on acute care floors strongly resembles the phenomenon of targeting described by Calliste (1996) and Das Gupta (1996); the “paranoia” described in a seminal study by Lemert (1962); the “horizontal” or lateral violence described by “critical nursing theorists” (Hedin, 1986; Roberts, 1983; Thompson, 1987); and the phenomenon of workplace “bullying” or “mobbing” described in the mobbing literature (Adams, 1992a; 1992b; Beasley & Rayner, 1997; Einarsen, 1999; Einarsen, Matthiessen, & Skogstad, 1998; Einarsen, Raknes, & Matthiesen, 1994; Einarsen & Skogstad, 1996; Ellis, 2000; Gorman, 1997; International Labour Organization, 1998;



Keashly, 1998; Leymann, 1990; 1993; 1996; 2000; Leymann & Gustafsson, 1996; Niedl, 1996; Rayner, 1997; Rayner, Hoel, & Cooper, 2002; Sheehan, 1999; Vartia, 1996; Zapf, Knorz, & Kulla, 1996; Zapf & Leymann, 1996). While the above researchers describe interactions that are very similar to some of the interactions that I observed or became aware of during my participant observation, or that were described by some of the interviewees, I also observed interactions that were related, but did not quite fit the descriptions provided by the above researchers. It was the same phenomenon, I thought, but looked different. I thought that the phenomenon on the nursing floors that I observed, especially on the acute care floors, needed a conceptual construct specific to nursing on those hospital floors. I thought of targeting on nursing floors, therefore, as “anxious competence” and “projection of incompetence on the other”.

“Anxious competence” is exacerbated by the factors of a nursing shortage, a faster pace of work, and uncertainty about the future of hospitals and nursing in general. The phenomenon of “anxious competence” and “projection of incompetence on the other” is also related to nurses’ training and education, where an intense fear of possible legal implications of medication errors or other mistakes is instilled. “This is a legal document” nurses remind themselves while charting, mindful of the invisible arms of the law and the ever-present possibility of losing one’s license. (The case of Susan Nelles is not forgotten – the newly graduated nurse in the Toronto Hospital for Sick Children wrongfully accused in 1984 of overdosing infant patients with Digoxin – Code, 1995).

“Anxious competence” and the “projection of incompetence on the other” is also related to the relative prestige or lack of prestige associated with different levels of

acuity among the patients. Nurses in "high functioning" acute care levels wish to maintain the prestige of their higher level of care by guarding it from contamination due to the entry of nurses from lower, stigmatised levels of care. The reputation of their floor as "high functioning" is guarded through the exclusion or expulsion of nurses thought to be less competent. The act of exclusion by targeting also defines or confirms for them the boundaries between what is "competence" and "incompetence" and affirms their own competence. This is important in terms of respect from selves and others, particularly professional others, since they perceive that respect for the profession of nursing has declined.

My interest in this area of study originated from reading the results of the well-known longitudinal Framingham Heart Study (Haynes & Feinbeib, 1980), showing that female clerical workers in the study were two to five times more likely than the study population as a whole to develop coronary artery disease. The authors of the study suggested that the nature of the women's work – high stress, low control – were implicated in these findings. A number of qualitative studies into the working conditions of female office workers ensued (for example, Hall, Stevens, & Meleis, 1992; Hessing, 1992; Johnson, 1989; Stevens, Hall, & Meleis, 1992), as did studies into the working conditions of other female-occupied, low control, and high stress jobs in health care (for example, Tierney, Romito, & Messing, 1990; Torkington, 1995; Weitzman & Berry, 1992), including my Masters thesis on the working conditions of female patient care aides (Jamieson, 1996). The findings of my study concurred with those of others in the field, such as the quantitative study by Tomascovic-Devey (1993) which suggested that in addition to the "high stress/low control" characteristics of unhealthy jobs, such jobs

are almost always segregated by gender and “ethnicity” (as well as class) in terms of who does what work, and where decision-making power is concentrated.

Despite the important role that nurses play in the delivery of healthcare, and the importance of retaining and recruiting more hospital nurses – especially in the present period when hospitals are experiencing a “nursing shortage” - there is little research into the working conditions and the perspectives of these (predominantly) women members of the hospital workforce.

The present study documents the changing nature of nursing work and the struggle of nurses to carry on with their work of providing quality health care in the present era of change and uncertainty. The findings of the study indicate areas in the administration of nursing and health care delivery that could be amenable to intervention and policy change, with the aim of improving workplace environments for nurses. Improving the workplace environments would have positive results for the health and well being of nurses, which in turn could have only a positive impact on the patients they care for.

### **Purpose and Questions of the Study**

It was assumed at the beginning of this study that the working environment on the hospital floor, which includes the interactive environment, could not but be informed by the two contextual themes of restructuring and job segregation. Two possible tendencies in the interactional working environment on nursing floors are explored: (a) exclusionary practices directed toward maintaining or guarding segregation and relative privilege of groups (or on the other hand, challenges by individuals to exclusionary practices); and (b) interactions directed toward inclusiveness and solidarity in the face

of a common threat of economic uncertainty (or on the other hand, interactions directed toward disruption of solidarity, for the enhancement of the individual).

The central research question of this study is: "What is the impact of restructuring on nurses' perception of their work, and on the interactional working environments of nurses working in three different levels of care on the hospital floors of two hospitals in Greater Vancouver?"

The sub questions are:

1. In what ways is hospital nursing work changing during the present era of restructuring?
2. How does hospital nursing work differ from one level of care to another?
3. What is the interactional environment like in a hospital nursing workplace? Does this differ from one level of care to another?
4. How does job segregation fit in? Are there processes of exclusion and inclusion during interactions on the hospital floor that maintain job segregation, or on the other hand, challenge it?

During the one-year data collection phase of the present study, data were obtained through participant observation and open-ended interviews. Participant observation was conducted on three different types of floors in each of the two hospitals, corresponding with three different levels of care. The nurses interviewed were recruited from the different levels of care, also. The reasons for choosing three different levels of care – extended, acute and critical –was to enable me to explore in more depth the phenomenon of job segregation on the basis of racialized ethnicity, which first became evident to me when I noticed that the extended care

levels employed the highest percentage of nurses of colour from formerly colonized countries, while critical care levels employed the lowest percentage of these nurses, in the hospitals where I did my fieldwork. I conducted lengthy open-ended interviews with 25 nurses from a number of hospitals in the Lower Mainland, including two union stewards, and also with 4 nurse managers. The initial interviews were carried out over a period of 6 months, with follow-up interviews with a smaller number of interviewees carried out over the next 6 months. I also made follow-up visits to the floors when I had completed the initial fieldwork, which lasted for 8 months. As well, I reviewed publications by the Registered Nurses Association of British Columbia (RNABC) from as far back as 20 years, publications by the British Columbia Nurses Union (BCNU) in the last decade, and bulletins issued by the administrators of the hospitals during my fieldwork.

### **The Background Theme of Restructuring**

These are times of great change in BC's health care system. Our challenge is to strike a balance between delivering sustainable health care to our patients, clients and residents, while at the same time resolving our deficit issue...many difficult decisions will have to be made. There will be shifts in programs and services, job losses and other changes...as we work together to renew our health care system. [Excerpt from a hospital bulletin, December 2001]

It was pointed out in the above bulletin that the B.C. Ministry of Health announced in December 2001, the restructuring of British Columbia's health care system – meaning that the province's 52 health authorities would become five Regional Health Authorities and a Provincial Health Services Authority. One of the new regional health authorities was the Vancouver Coastal Health Authority, encompassing the three "Health Services Delivery Areas" of Vancouver, Richmond, and North Shore/Coast Garibaldi.

Although restructuring was presented as something new in hospital bulletins, in

fact, it had been ongoing for at least a decade, not only in B.C. but also in the other provinces and territories as well. In early 1993, the B.C. Provincial government announced the closure of Shaughnessy Hospital – a major teaching hospital in Vancouver - and by the end of that year almost all its programs and staff were relocated to other facilities throughout the Lower Mainland. During and after the closure of Shaughnessy Hospital, smaller hospitals in the Vancouver area were amalgamated with one or the other of the two remaining large ones. For instance, the smaller formerly Catholic hospitals such as Mount St. Joseph's, and St. Vincent's along with the larger St. Paul's Hospital were then considered part of the same entity called Providence Health Care. Similarly, Vancouver General Hospital was renamed Vancouver Hospital and Health Sciences Centre, which was the entity to which other smaller hospitals also belonged, such as G.F. Strong Rehabilitation Centre, University of British Columbia Hospital, and Pearson Hospital. Other facets of restructuring followed, or had been occurring, such as "regionalization" of hospital boards and community health boards (which were previously autonomous) into broader regional health boards. New management techniques like Total Quality Management (TQM) were introduced into hospitals at this time (Armstrong, Armstrong, Choiniere, Mykhalovsky, & White, 1997).

In the present era of restructuring, governments at the provincial and federal levels, along with non-governmental organizations and community organizations, are engaging in heated debates about the "crisis" in health care, and the future of health care delivery in the province and across Canada. (Angus & Turbayne, 1995; Barlow, 2002; Begin, 1999; Cohen & Pollak, 2000; Fuller, 2002; Government of Canada, 2002; Kent, 2000; Province of Alberta, 2000; Province of British Columbia, 1991; Provincial

and Territorial Ministers of Health, 2000; Rachlis, 2000; 2001; Saskatchewan Commission on Medicare, 2001; Siler-Wells, 1988; Standing Senate Committee on Social Affairs, Science, and Technology, 2002).

The B.C. government, like other Canadian provincial and territorial governments, claims that major cutbacks in federal transfer payments to the provinces and territories for health care in the mid 1990's necessitated "streamlining" services, closing some hospitals and programs, and entering into "public/private partnerships" to help fund health care.

The annual meetings of provincial and territorial health ministers, and the numerous reports from both provincial and federal levels of governments concerning the plight of the health care system are reflective of the continual negotiations between the federal and provincial governments about who should be responsible for health care funding. In 1957, Canada's national hospital insurance program was established, and until 1977, the federal government contributions to acute hospital care and doctors' services matched provincial spending, dollar for dollar (Dunlop, 1985). In 1977, the federal government began "to withdraw" from this arrangement, and by the mid 1990's had made substantial cuts to its transfer payments to the provinces (Provincial and Territorial Ministers of Health, 2000). In response, the provincial and territorial ministers held numerous summit meetings to attempt to formulate collective positions on the amount of funding of health care that provinces should be responsible for, and the degree of control over the delivery of health care that they should have vis a vis the federal government (Provincial and Territorial Ministers of Health, 2000). Extensive studies and reports on the future of health care and health care funding were published

by both levels of government, including the Kirby Report (Health Canada, 1999), *Understanding Canada's Health Care Costs* (Provincial and Territorial Ministers of Health, 2000), the Mazankowski Report (Province of Alberta, 2000), and the Romanow Report (Government of Canada, 2002). Cumulatively, these reports represent the state of negotiations between the federal and provincial (and territorial) governments concerning funding and control over health care delivery.

In August 2000, Canadian provincial premiers and territorial leaders held a conference in Winnipeg, Manitoba about the future and "sustainability" of the health care system. *Understanding Canada's Health Care Costs* (Provincial and Territorial Ministers of Health, 2000) is the final report of that conference, submitted to the federal government under the aegis of the Provincial and Territorial Ministers of Health. The Report notes that since the 1977/78 fiscal year the federal government began to "retreat" from health care financing (Provincial and Territorial Ministers of Health, 2000; p.3), and in 1982/83 they reduced the transfer to the provinces by about \$1 billion. In 1996/97, the transfer funding was reduced from \$18.4 billion to \$14.7 billion, and in the following 2 years, to \$12.5 billion. The main recommendation of the Report is the demand by the provincial and territorial premiers that the federal government immediately restore the federal funding for health care to its previous levels. The intent of the Report was also to demonstrate to the federal government that the provinces/territories had already been undertaking "health system renewal and innovations" since the mid-1980's, in response to the demand of the federal government that the provinces and territories must first develop a plan to "reform" or restructure their health care system (allegedly to make them more cost effective) before



any further increases in federal funding would be forthcoming.

The federal government began to give back some of the deleted funding (Provincial and Territorial Ministers of Health, 2000). In the 1999/2000 federal budget, a one-time supplement of \$3.5 billion was given to the provinces for health care and a \$2.5 billion increase in the cash base amount to be transferred was slated over a 3-year period, beginning in 2000.

The impact of restructuring on hospital workplaces has been quite severe. In Canada, as in other industrialized societies, the work people do is central to their social identity, their mental and physical well being, and is the basis for respect from self and others. The results of a recent international study of workplaces (International Labour Organization [ILO], 2000), however, suggest that since the beginning of the era of "restructuring" – around the early 1990's - workplace environments in North America and Europe have been causing increasing rates of ill health among those who work in them. Hospitals figure prominently in these studies.

Characteristics of poor workplace environments identified in the above study include the faster pace of work, uncertainty about the future, lack of control over work, increased supervision, increased surveillance, and "mobbing" (also referred to in that study as "workplace bullying"). Most characteristics of poor workplace environments identified in the above study have been associated in earlier studies (for example, Clement & Myles, 1994; Tomaskovic-Devey, 1993) with lower echelon jobs.

Some researchers in health care (for example, Brannon, 1994; Campbell, 1992) consider that nursing work has changed during this period of restructuring and cost-containment, and has begun to take on characteristics of less desirable or lower

echelon jobs – characteristics like increasing routinization of the work, a greater division between conceptual and physical labour, increased surveillance by a new managerial class, high stress and lack of control over the job.

For purposes of recruitment and retention of nurses in the workforce, nursing management studies (for example, Price & Mueller, 1981; 1986) have traditionally posed questions like “what makes a job more interesting or rewarding?” or “how can management reduce sick time and turnover?” The roots of this approach reach back to the Tavistock School of management in England (Braverman, 1974).

The Price and Mueller study (1986) is an example of nursing management literature that reflects a transition from traditional management perspectives in nursing, towards models arising during the era of “cost-containment” identified by writers such as Brannon (1994). Price and Mueller documented a 42-58% turnover rate of hospital nurses in the U.S. over a period of ten years - a much higher rate than [other predominantly female] professions such as school teachers (13-17%), and social workers (30-34%). Using a systems and “social control” perspective, they attribute the high turnover to ineffective organizational control that fails to keep trained personnel sufficiently motivated to obey official hospital norms, thus ensuring optimal output and continuing resource input (payments to hospitals).

In contemporary nursing management literature, a new question is posed [paraphrased]: “How can the quality and outcome of nursing work be assured in the era of cost containment?” (for example, Garner, Smith, & Piland, 1990; Loveridge & Cummings, 1996). Critics of the new “audit environment” (for example, P. Parkin, 1995; Stronach, Corbin, McNamara, Stark, & Warne, 2001) fear that the new management

paradigm threatens the professionalism of nursing and contributes to its proletarianization and/or bureaucratization.

The ILO study cited above links "restructuring" with a rising incidence of mental and physical health problems among members of workforces in North America and Western and Eastern Europe. The effects of "cost-containment", "downsizing" and reorganization of resources is likewise a salient theme in many recent studies of women's work in the service sector in general (for example, Connelly, 1996; Duffy, Glenday, & Pupo, 1997; Woody, 1989), and in health care in particular (for example, Angus & Turbayne, 1995; Armstrong, Armstrong, Choiniere, Mykhalovsky, & White, 1997; Benner, Tanner, & Chesla, 1996; Brannon, 1994; Kunes-Connell, 1991; Siler-Wells, 1988; Twaddle, 1996).

In an ethnography of nursing work among acute care nurses in Vancouver, B.C. the author notes "a climate of fear and uncertainty" at the hospital sites where she conducted her fieldwork, because "nursing units are being frequently closed, rearranged, and/or reshuffled, and entire hospitals are uncertain about their futures" (Rodney, 1997; p.147). In a qualitative study of occupational self-esteem and identity among psychiatric nurses in the U.S. one study participant remarked: "Nurses are afraid and they don't know what they are afraid of, they just feel that their role has been uprooted" (Kunes-Connell, 1991; p. 138).

Arnold (1996) eloquently describes the well-known phenomenon of "burnout" among nurses and decreased mental well being associated with restructuring, thus:

The burnout syndrome, particularly acute among nurses, has been described as the literal collapse of the human spirit brought on by a sense of acquiescence and powerlessness...in situations and working environments that are high pressure and where work roles are often in conflict (p. 313).

On "World Mental Health Day", October 10, 2000, the World Health Organization (WHO) and the International Labour Organization (ILO) co-sponsored a two-day conference on "mental health and productivity". Participating organizations included the World Federation for Mental Health, and the Business and Economic Roundtable on Mental Health, based in Toronto. To coincide with this date, the ILO published *Mental Health in the Workplace* (ILO, 2000) – the summation of studies in 5 countries (Finland, Poland, Germany, UK and the U.S.) financed by a grant from the Eli Lilly and Company Foundation (a major pharmaceutical monopoly). Its purpose was to determine "the scope of the problem in a competitive environment". All studies showed a marked increase of illnesses due to work-related stress since the early 1990's including mental health disorders such as anxiety, depression, burnout and suicide. The report states that mental health disorders are a leading cause of illness and short term disability, affecting at least 1 in 3 workers (the Finnish study reports 50% of the workforce), second only to musculoskeletal injuries. It notes that mental health and behavioral disorders have overtaken cardiovascular disease and diseases of the musculoskeletal system and connective tissue as the most common reason for early retirement and disability pensions.

A main concern of the ILO and the monopolies that support these studies is the economic costs associated with mental disabilities in the workforces. Figures are given regarding typical costs to the employer for a 3-month sick leave; and costs to governments in lost tax contributions, sickness allowances, medical and other costs of rehabilitation. Figures are given regarding the numbers of millions of lost working days due to mental health disorders, and the proportions of Gross Domestic Product (GDP)

spent on treating and trying to prevent these mental health disorders.

The ILO study (2000) contains numerous references to "mobbing" behaviour at the workplace. Follow-up on the references provided in the study yielded a moderately large field of literature and research on "mobbing" - also variously termed "workplace bullying", "psychological terrorism", emotional abuse, harassment, or victimization. As well as articles in journals and chapters in books, a number of articles have been posted on a website called "Foundation for the Study of Work Trauma" (2000).

Einarsen (1999) defines workplace bullying as "hostile and aggressive behaviours directed systematically at colleagues or subordinates leading to the stigmatization and victimization of the recipient. " He observes that "The situation then seems to affect the mental and physical health of the victim quite dramatically". Ellis (2000) cites research compiled at the University of Manchester Institute of Science and Technology indicating that between one third to one half of all stress related illness is directly attributable to bullying at the workplace. He notes that the cost to organizations in terms of lost productivity and employee sick leaves is very high.

Keashly (1998) states that there is increasing evidence that psychological forms of aggressive behaviour are more frequent than physical assaults at work, and that the former kind of assault is equally and perhaps more devastating than the latter for employees both as targets and as witnesses to it.

An ILO study (1998) entitled "Violence on the Job – a Global Problem" was based on a survey by the Canadian Union of Public Employees (CUPE) conducted in 1994 in Ontario hospitals. It showed that 74% of the respondents believed verbal aggression was the leading form of violence against them. A table of prevalence of

rates of victimization at the workplace in 38 countries or regions was presented. It showed the highest prevalence rates in Western Europe, Britain, France, Netherlands, Switzerland, Romania, Yugoslavia, Canada, and the U.S. The prevalence of victimization of women at work was higher in Canada than in most other countries (including the U.S.) except for Britain, France, and Argentina.

The finding in the above study that patients accounted for such a negligible proportion of incidents engendering distress among health care workers is surprising in light of the large body of literature about workplace violence in hospitals, in which patients are identified as the main source of violence (for example, Duncan, Hyndman, Estabrooks, Hesketh, Humphry, Wong, Acorn, & Giovannetti, 2001; Hesketh, Duncan, Estabrooks, Reimer, Giovannetti, Hyndman, & Acorn, 2003).

Sheehan (1999) considers that there is a strong relationship between bullying at workplaces and widespread uncertainty resulting from the restructuring of organizations. Downsizing, "de-layering" (the vertical compression of managerial levels of hierarchy), the planned elimination of jobs, and the introduction of new technologies, Sheehan argues, all increase organizational demands and stress on managers which "tend to lower the threshold at which managers, particularly those operating at the limits of their skill competencies, might adopt bullying behaviours – even if involuntarily" (McCarthy, 1996, cited in Sheehan, 1999). Duncan, Hyndman, Estabrooks, Hesketh, Humphrey, Wong, Acorn, and Giovannetti (2001) also found that hospital restructuring was a predictor of emotional abuse directed toward nurses in B.C. and Alberta, along with the factors of age, job status (full-time versus casual), quality of care, type of unit, relationships among hospital staff, nurse-to-patient ratios, and violence-prevention

measures.

The mobbing literature remains mostly descriptive rather than analytical. Nevertheless, this body of literature does help to illuminate interactional themes on hospital floors.

### **The Contextual Theme of Job Segregation**

While health care restructuring has been a dominant contextual theme overshadowing the work of hospital nurses in Vancouver and the Lower Mainland since 1993, job segregation has been salient for at least the same length of time. Job segregation in health care is more visible than restructuring, but conversely is rarely talked about nor even noticed by those in the “mainstream” of hospital work.

Nursing itself is the most gender-segregated of all healthcare occupations: Women make up between 85-87% of the B.C. health care workforce as a whole, while almost 97% of the 31,000 registered nurses in B.C. are women (Fuller, 2002; p.295). Nurses' wages are lower than those of men who work in other sectors, even when their length of training is better or comparable (BCNU, cited in Fuller, 2002).

Within the gender-segregated profession of hospital nursing in Vancouver and the Lower Mainland, women of colour whose origins are from formerly colonized countries are found mainly in less prestigious areas of nursing such as extended care, while white nurses of Anglo or European origins occupy more prestigious areas such as critical care. This fact is observable when one walks throughout the hospital, from one level of care to another, as I did in the beginning of my studies<sup>3</sup>. My observations were borne out in my interviews with front-line nurses from all over the Lower Mainland, when

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<sup>3</sup> No statistics were found regarding ethnic composition of nursing working groups on different levels of care.

I confirmed my observations with them.

The de facto segregation of the nursing workforce on the basis of racialized ethnicity exists in other areas besides Vancouver (Arnold, 1996; Brand, 1993; Brannon, 1994; Bryan, Scafe & Dadzie, 1985; Calliste, 1996; Das Gupta, 1996; Glazer, 1991; Hemmons, 1996; Jamieson, 1996; Mason, 1995; Woody, 1989), and correlates with different types of nursing work, different working conditions, and different levels of prestige.

Within the different levels of care themselves (which are de facto segregated in this study), however, relations of domination and subordination can be observed occurring between nurses who are both (or all) nurses who are members of white Anglo European backgrounds; between members of the latter group and nurses who origins are in formerly colonized countries; and between nurses who are both (or all) members of the latter group. This point, which is discussed at greater length in Chapters Five and Eight, hints at the complexity of the relationship between gender, racialized ethnicity, and class.

The hospital nursing workforce, then, comprises a large group of people with generally low status compared to a few other hospital-related professions (such as physicians and administrators), yet with "relative advantage" (Wolf, 1992) compared to some other occupations in the hospitals, such as housekeeping (Torrance, 1994). A similar gradation of relative advantage occurs within the occupation of hospital nursing itself, which is rife with all sorts of contradictions that impact on the work experiences of women. The "multiple and contradictory intersections of race, class, gender" (Creese & Stasiulis, 1996; p.5) are implicated in relative advantage or disadvantage for nurses in



the hospital hierarchy, and within each of its echelons. The larger political and economic context in which working experiences are embedded, is mediated through these multiple and contradictory intersections of racism, class, sexism, and other attributes (Andersen & Collins, 1995; Berberoglu, 1994; Brand, 1993; Chow, Wilkinson, & Zinn, 1996; Comack & Arat-Koc, 1999; Creese, 1992; 1999; Creese & Stasiulis, 1996; Das Gupta, 1994; Kandal, 1995; Kendall, 1997; Ng, 1990; 1994; 2001). In his study on the causes and effects of job segregation Tomaskovic-Devey (1993) found an interacting effect between gender, ethnicity of job occupants and the prestige of that occupation. Reskin and Roos (1990) examined the feminisation of the occupations of pharmacy and baking, and found that the rise of female participation in an occupation or profession is usually accompanied by increased "intra-occupational segregation", job deskilling, and decline in wages.

Job segregation impacts on how nurses as a whole, and nurses in various job categories experience restructuring. Calliste (1996) and Hemmons (1996), for example, consider that surveillance practices by health care management have become more racialized during cost containment and economic restructuring, and that Black health care workers have been suffering a disproportionate loss of jobs.

An important outcome of occupational segregation and low status is the differential health outcomes associated with different locations in a segregated workforce. There is ample epidemiological and other research showing that members of racialized minorities, women in lower echelon jobs, and members of the working class have higher rates of mortality and morbidity than do the rest of the population (Aitken, 1995; Arnold, 1996; Aston & Lavery, 1993; Bolaria, 1988; Bryan, Dadzie, & Scafe,

1985; Doyal, 1995; Fernando, 1992; Franks & Faux, 1990; Frohlich & Mustard, 1996; Hare & Pratt, 1988; Haynes & Feinbeib, 1980; Hemmons, 1996; Henry, Tator, Mattis, & Rees, 1995; Jamieson, 1995; Johnson, 1989; Krieger & Fee, 1996; Lewy, 1991; Mason, 1995; Province of British Columbia, 1995).

An important aspect of job segregation that should be mentioned here is the de facto exclusion from hospital nursing of some recent immigrant nurses mainly from the Philippines. In the 1970's, nurses were actively recruited from the Philippines as well as from other parts of the world, to work in Canadian hospitals, as is pointed out by some of the interviewees in this study. At present, however, this is not the case.

A very small number of Philippine-trained nurses have immigrated here as dependents of their husbands, and an even smaller number have immigrated as independents (Philippine Women's Centre, 1997; and interviews with members of the Filipino Nurses' Support Group). Nurses in the Philippines find that when they apply to emigrate to Canada, they are usually awarded less than the minimum 67 "points" stipulated by the Canadian Immigration Department (2004) for entry as an independent. As some interviewees point out, it is much "easier" for nurses to enter Canada through the Live-In Caregiver Program (LCP), which allows them into the country only as domestic workers rather than as nurses. In the terms of their agreement with the LCP, nurses who enter Canada this way must live in employer households as live-in domestic help for a period of two years, during which time they are not allowed to take courses, or apply to work as nurses. At the end of that time, many apply to and/or are hired by extended care facilities or in extended care floors of hospitals. A representative of the Filipino Nurses Support Group states that the Provincial Nominee Program (PNP),

instituted in the year 2000 “has not worked” in terms of increasing the numbers of Filipino nurses immigrating to B.C. as nurses, and decreasing the numbers of Filipino nurses arriving here via the LCP. (The PNP was to have made it unnecessary for Filipino nurses to apply through the LCP to come to B.C.). No relevant statistics were found concerning this matter. The issue of the de facto exclusion of Filipino nurses from the hospital-nursing workforce is discussed again later in Chapters 5 and 10.

### **Nurses as Legitimate Research Subjects in Their Own Right**

While there are a number of studies about other women’s work in the service sector (for example, Connelly, 1996; Duffy, Glenday, & Pupo, 1997; Woody, 1989), and there are numerous studies about changes in the health care system (for example, Angus & Turbayne, 1995; Armstrong, Armstrong, Choiniere, Mykhalovsky, & White, 1997; Brannon, 1994; Siler-Wells, 1988; Twaddle, 1996), there are fewer studies about nurses’ own perspectives on their work.

Studies about nurses’ work that do exist usually focus on nurse-patient interactions for the purpose of quality improvement of patient care (for example, Hibberd, 1999), and/or to bolster claims of a distinct niche and professional status for the work (for example, Benner, Tanner, & Chesla, 1996). It is almost as though nurses themselves, as women, do not exist or are not interesting enough to study. This gap is all the more glaring at the present time when a “nursing shortage” is exacerbating a more general crisis in health care – a crisis that nurses and other health care workers are actively confronting on behalf of the public as well as for themselves.

With the exception of a small number of recent studies about racism in nursing and horizontal or lateral violence (cited above), previous inquiries into the working

conditions of nurses have tended to emphasize the physical and emotional demands of providing patient care, and have neglected the interactive environment among nurses themselves (that is, the social environment created by interactions during work). Still less has the interactive environment at the place of work been studied as a function of the larger context of health care administration, unions, and government economic policies, within which the interactions take place. In the few studies that have considered the interactive environment in which nurses work, interactions have been characterized as mutually supportive (Calliste, 1996; Coulter, 1993; Rodney, 1997; White, 1993) or divisive and mutually antagonistic (Hedin, 1986; Roberts, 1983) involving relationships of domination and exclusion (Calliste, 1996; Das Gupta, 1996; Campbell, 1988; Thompson, 1987) and also resistance (Calliste, 1996; Campbell, 1998). Like Devault (1999) who has made it her mission to "excavate" the invisible or ignored aspects of women's lives, the present study starts with the everyday work and lives of nurses, much of which has been largely invisible or ignored.

### **Outline of the Study**

A discussion of the conceptual framework and methodology of the study follows in Chapters 2 and 3. Chapter 2 is a discussion of the usefulness of social constructionism, labour process theory, and feminist writings in critical social theory, and the suitability of these traditions to the aims of the present study. Chapter 3, on Method, includes a discussion of the research method of institutional ethnography, and a description of the study design.

In the tradition of ethnography, Part Two - "The People, the Place, and the Work" contains extensive excerpts from interviews and notes, providing rich description of the

physical setting of nursing work, the members of the nursing work groups, and their work. This provides not only “confirmability” for the reader, but I hope also sparks in the readers a kindred fascination with hospitals and hospital nursing work that was rekindled in me during this study. It also gives the reader advance familiarity with physical artifacts and work practices that nurses refer to in their interviews later in the study.

In Chapter 4, I introduce the members of the working group – the main local site of interaction of front-line nurses. I present illustrative pictures of the people who fill the key roles in it: the front-line nurses themselves, the manager of the floor, the union steward, the nurse clinician, and the unit clerk. Excerpts from interviews and records of interactions are included. Chapter 4 also contains descriptions of the physical layout of the hospital floors, including technologies used in the hospital. Also in Chapter 4, a beginning description of the nature of front-line nursing work is introduced.

While Chapter 4 is mostly descriptive, Chapter 5 is analytical as well as descriptive. The section “Classes and hierarchies in nursing work” in Chapter 5 contains extensive excerpts from transcribed interviews, in which study participants talk about the nature of their work. Conceptually, it is divided into one section on hierarchy, where issues such as levels of prestige are explored; and another section on the nursing labour process, in which the changing nature of nursing work itself is explored.

Chapter 6, “Distress: Narratives of Restructuring and Ethical Dilemmas”, is a continuation of the description of the problematics of work introduced in the previous chapter. Its focus is on themes arising from nurses’ experiences and accounts of restructuring, and on the ensuing ethical dilemmas they face. Together with the

preceding two chapters, this helps to set the stage for Part 3, in which interactions among nurses, including dysfunctional patterns of interaction, are examined.

Part 3, "Everything is Politics", contains more data about interactions among nurses, and preliminary analysis of this data. The social construction of competence and the politics of its management and surveillance are explored in Chapter 7, while in Chapter 8, the social construction of "incompetence" is examined through two case studies of targeting incidents. The case studies include interviews with other nurses participating in the targeting episodes (including a manager), as well as extensive interviews with the targeted nurses themselves. Analysis follows in the "Discussion" section at the end of the chapter.

In Chapter 9, the importance of resistance and solidarity among nurses is explored and documented. This includes formal and informal resistance, social events as solidarity building, and the tenuous role of unions.

In Chapter 10, the Conclusion, I discuss and integrate the findings from the ethnographic data to reach conclusions about the changing nature of the labour process in nursing work, and the origins of problematic interactions in the workplace environment. I propose areas for policy changes in health care delivery and management that would improve the working environments of front-line nurses. I discuss the contributions of the present study to social constructionism, labour process theory, and feminist critical social theory, and suggest areas for further research.

## CHAPTER TWO: THE CONCEPTUAL FRAMEWORK

The conceptual framework of this study is informed by social constructionism, Marxist labour process theory, and selected feminist writings in the tradition of critical social theory. Critical social theory is loosely associated with the "Frankfurt School"<sup>4</sup>. Authors commonly identified with this approach include Marx, Horkheimer, Adorno, Bordo, Bourdieu, Butler, Foucault, Habermas and Marcuse. Some feminist nursing theorists use this theoretical approach (for example, Campbell & Bunting, 1991; Hall, 1999; McLain, 1988; Meleis, 1991; Stevens, 1989; Stevens & Hall, 1992). One branch in critical social theory has given rise to the Marxist-inspired model of feminist "standpoint" research, which offers a compelling perspective from which to view the origins and effects of ongoing social change on hospital workplaces and the people who work in them. Examples of feminists often identified with standpoint research include Collins (1991a; 1991b; 1998), DeVault (1991), Harding (1986; 1991; 1998), Hartsock (1993; 1998), Smith, (1986; 1987; 1990b; 1992; 1999), and Wolf (1996).

Marxist labour process theory, on the other hand, provides a valuable framework in which to view and analyse the specifics of hospital nursing work itself, and changes in that work. Braverman (1974) and Burawoy (1979) are two prominent names in the field of labour process theory, whose treatises generated over two decades of debate in this field (Brown, 1992).

The perspective of social constructionism, in the present study, fleshes out the descriptions and understanding of hospital nursing work, examined mainly from the

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<sup>4</sup> Critical social theory is a label used by the Frankfurt School (that is, members of the Institute for Social Research of the University of Frankfurt, their intellectual and social network, and those influenced by them intellectually) to describe their own work, oriented toward radical social change, in contradistinction to

perspective of labour process theory, and helps to explain the dynamics of behaviour among members of the working groups on nursing floors, and the meanings that nurses and others ascribe to aspects of their work. It helps to explain how hospital hierarchies are maintained. Lastly, social phenomena such as “competence”, in light of the social constructivist approach, are understood to be at least partly negotiated through social interaction – that is, socially constructed – rather than as necessarily measurable entities. Critical social theorists who are feminists, such as Smith (1990a), have long incorporated the approach of social constructionism into their critique of power relations.

The aim of the study, which the above theoretical approaches facilitate, is to make visible to the nurses, the researcher, and to the readers, the social forces that are exerting influences upon the working environment of nurses – including the interactive environment - and thus upon their experiences of work. This in turn can enable nurses and others to act upon the heretofore-unseen social forces, to control to some extent, or attenuate unpleasant or harmful influences upon their work and workplace interactions.

### **Feminist Critical Thought and “Standpoint Theory”**

The stance of starting research from the actualities of women’s lives (or the lives of any specific group of people) is known as “standpoint” research, which has given rise to the concepts of “standpoint epistemology” and “standpoint theory”. Writers identified with this branch of research include Campbell (1998), Collins (1991a; 1991b; 1998), Denzin (1997), DeVault (1999), Harding (1986; 1991; 1998), Hartsock (1983; 1998),

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“traditional theory” – that is, theory in the positivistic, scientific, or purely observational mode (Wikipedia,



Hennessey (1993), Wolf (1996), and Dorothy Smith (1986; 1987; 1990b; 1992; 1999)<sup>5</sup>.

Smith (1992, p.91; 1999), however, identifies her project as the development of method rather than theory - a new method of inquiry that begins from the standpoint of women in their everyday lives, rather than from an extra local point of departure.

Harding (1991; p.121), on the other hand, talks about "standpoint theory". She introduces the term "strong objectivity" which she characterizes as a "competency concept" (1991;p.149) aimed at maximizing objectivity in scientific research, which necessarily entails extending the notion of scientific research to include the systematic examination of the powerful background assumptions and beliefs inserted from the social order into the minds of researchers, but largely unacknowledged by them. She states:

...if the larger culture is stratified by race and gender and lacks powerful critiques of this stratification, it is not plausible to imagine that racist and sexist interests and values would be identified within a community of scientists composed entirely of people who benefit - intentionally or not - from institutional racism and sexism (143).

In a similar vein, Collins (1991b) states:

As outsiders within, Black feminist scholars may be one of many distinct groups of marginal intellectuals whose standpoints promise to enrich sociological discourse...[and] may reveal views of reality obscured by more orthodox approaches. [We have] certain common experiences, which in turn may predispose us to a distinctive group consciousness (p.30).

She adds that " dominant groups have a vested interest in suppressing such thought".

Like other critical social theorists, Collins (1991a) articulates a materialist approach to

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<sup>5</sup> Smith (1992, p.91; 1999) considers that the notion of a standpoint of women does not stand by itself as a theoretical construct and she thinks that the theorizing of standpoint within feminist discourse has displaced the practical politics that the concept of "standpoint" originally captured, reducing it to a purely discursive function (Smith, 1992,p.89). She does count herself among feminist thinkers like Jane Flax, Nancy Fraser, and Nancy Hartsock (cited in Smith, 1987; p.13) who "have adopted the device of a feminist or women's standpoint to address epistemological issues raised by feminism". Her conception and those of her colleagues such as Alison Griffith and Ann Manicom (cited in Smith, 1987. p.177) differ

knowledge formation:

...concrete experiences can stimulate a distinctive Black feminist consciousness concerning that material reality.... the commonplace taken-for-granted knowledge shared by African American women growing from our everyday thoughts and actions constitutes a first and most fundamental level of knowledge (p. 30).

Similar to Smith (1986;1987;1990b), Collins (1991a) considers that knowledge originating from the everyday experiences in a particular locale can be developed to a higher level through research by a "specialist" who participates in the group and then emerges to re-conceptualise and disseminate the knowledge, making it part of the general consciousness. General consciousness of group members, she adds, can stimulate resistance:

Experts or specialists who participate in and emerge from a group produce a second, more specialized type of knowledge. The two types of knowledge are interdependent. [R]earticulated consciousness empowers African American women and stimulates resistance (p.30).

This point is analogous to Marx's (1972 [1867]) idea about the development of working class consciousness. It is relevant to the present study, in which I as the sociological researcher have emerged after a prolonged period of participation in the working lives of hospital nurses, to bring light to those experiences using the framework of the theories discussed above – that is, from the perspective of a social scientist.

In contrast to more established approaches to sociological research, Smith (like other feminists in the critical social tradition) argues that data about women and other people collected by the intelligentsia of established sociology have been selective, and gathered to serve the needs of the "relations of ruling" (or "apparatus of ruling") for purposes of management. Relatedly, in her discussion of the social construction of mental illness, Smith (1987) writes:

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from the former, she says, in that they locate women's standpoint "outside discourse-in-texts"

There is a process of practical interchange between an inexhaustibly messy and different and indefinite real world and the bureaucratic and professional system which controls and acts upon it. The professional is trained to produce out of this the order, which he believes he discovers in it...In other institutional contexts, the local and particular forms are worked up to intend the categories and concepts through which they are entered into organizational courses of action (p.159).

Conventional researchers are not only unaware of the socially and historically contingent

nature of their formulations, Smith thinks, but also wittingly or unwittingly, form an active part of the relations of ruling that manage and shape the everyday worlds of women and others.

"The relations of ruling" states Smith in a Weberian analogy, are rationally organized (1987; p.4). Like Harding, Smith (1987; p.4) observes that while the ruling apparatus has claimed neutrality and objectivity, it has a definite "gender subtext" which up to now has been invisible. The gender division of work, she adds, is integral to its organization:

At best we have played a subordinate role, being accorded the manual and non-specific tasks that are essential to its functioning. As secretaries, we have done the secretarial work translating thought and design into the material forms in which the latter are efficacious as communication ( p.152)

Harding's question - "why is the standpoint of women or of feminists less partial and distorted?" (1991; p.121) - seems to lend itself to criticisms of essentialism, according to authors like DeVault (1999 ) who thinks that some of Harding's answers to her own rhetorical question appear to give "epistemic privilege" to women compared to men. For instance, Harding states that women give a valuable perspective as "strangers" to the social order; and since knowledge emerges for the oppressed through the struggles they wage against their oppressors, then women have created knowledge through their struggles against "male supremacy". Harding's question seems to suggest

to her critics (who have criticised Smith on the same basis) that women have a better view of "nature and social relations" by virtue of being women, to which Smith (1992) replies:

My notion of standpoint doesn't privilege a knower. ...It shifts the ground of knowing, the place where inquiry begins. Since knowledge is essentially socially organized, it can never be an act or an attribute of individual consciousness (p.9).

As she (1987) previously mentioned: "[O]ur own situations are organized and determined by social processes that extend outside the scope of the everyday world and are not discoverable within it (p. 152). On this point, Harding and Smith agree.

Harding (1991) writes:

the other [position to avoid] is the tendency, in reaction to this ahistoricism, to insist that the spontaneous consciousness of individual experience provides a uniquely legitimating criterion for identifying preferable or less false beliefs. This can be thought of as experiential foundationalism (p.269).

While Smith insists that what she has been writing about is method rather than a theory, she is keenly aware of the relationship between method and theory. Established sociological discourse, she says, is produced from a (concealed) standpoint in the ruling relations and its methods serve that viewpoint. She states " Its research methodologies harvest information, data, and other forms of knowledge derived in various ways from people and what they have to say, and bring them home to the text-based discourses housed in universities " (Smith, 1999, p.16). She emphasizes that the method of inquiry has important implications both for how research is done, and for how the researcher thinks about society and social relations. She states "I'm not proposing just an alternative method of inquiry; rather, I am also looking for a revision of the relations of knowing" (1999; p.94). She states that her project of developing a new method is part of an overall project in the development of a "feminist sociology" (1987).

She (Smith, 1999) describes the dilemma that a researcher using a feminist method experiences when having to "work up" the data into existing sociological discourse, since the new sociology does not yet exist:

a moment comes after talk has been inscribed as texts and becomes data when it must be worked up as sociology...a feminist social consciousness, grounded in experiencing and insisting on knowing from where women are, is redirected into the older paths of a patriarchal organization of knowledge as we work within the conventions of sociological discourse (p.46)

In a parallel vein, Collins (1991a) found her training as a social scientist "inadequate to the task of studying the subjugated knowledge of a Black women's standpoint" (p.202).

Critical social theorists who use the idea of standpoint in feminist research acknowledge the Marxist model of the proletarian standpoint as their inspiration, which as Harding (1991) notes, was a development of the Hegelian idea that in slave society, the slave who worked with his hands to produce material goods had a better knowledge of material reality than the master who was not directly involved in production. (In this, Hegel was a materialist, though his ideas on the state and higher knowledge were idealist).

Smith and the feminist scholars noted above use the Marxist conception of standpoint as a simile. They see a parallel between the proletarian/bourgeois relationship to knowledge, and that between women and men (Collins sees it from the standpoint of African-Americans and Black feminists in relation to dominant groups). Smith, DeVault, and Hartsock do not identify any one standpoint as a more valid viewpoint at which to begin investigation, as long as it locates itself in the particularities of the lives of some members of the society, rather than pretending to take a standpoint

somewhere outside society.

The idea that women and other marginalized people can become aware of how they are socially situated only after research has begun from their standpoint is analogous to the Marxist principle that the formerly individualized members of the working class become conscious of themselves as a class in opposition to an exploiting class, only after the introduction of scientific investigation and the development of theory from their standpoint. According to the Marxist analysis, however, this cannot happen outside the context of production and class struggle. There is no similar mechanism or motor to propel research forward in Smith's framework or that of the other feminists writing in the critical social tradition - only the intention that the research will serve as a useful resource or inspiration for groups engaged in efforts at change (for example, Collins, 1991a; DeVault, 1999).

The writings of these feminists in the tradition of critical social theory provide a useful approach to the examination of hospital workplaces, starting from the lived experiences of nurses in them. This approach promises to make visible in sharper detail the pathways through which nurses' interactions and experiences in hospital working groups are connected to countless other similar working groups, with similar themes of interaction and work experiences, and it helps to explain why this is so. Their insights complement the labour process literature, which is discussed next.

### **Labour Process Theory**

"Your work is what you are... your work is your life"  
( Byerly, cited in Collins, 1991a, p.43)

Braverman (1974) notes that during the time of nascent capitalism, artisans exercised their conceptual and physical capabilities when they produced goods, but this

was not the case later in history, as the conceptual part of the labour process became separated from the physical, and the producers became separated from the end products of their labour. Marx (1972 [1867]; p.170) describes the effect this division has on the perception of the workers toward their work:

The purposeful nature of their work, then, gets turned into merely having to pay attention to endless details in one part of the production. Instead of perceiving their work as fulfilling, the workers find it mindless and distasteful. The worker's purposive will, manifesting itself as attention, must be operative throughout the duration of the labour. The less attractive is the work in itself, the less congenial the method of work, the less it is something which gives scope to bodily and mental powers - the more closely must attention be devoted to the task.

Alienation from the end product of the labour process described by Marx has been interpreted by some authors (for example, Erikson, 1990; Rinehart, 1996; Schweitzer, 1981) to mean chiefly mental alienation. The two aspects of this construct have been combined in the concept of degradation of work (Braverman, 1974) and more recently, routinization of work (for example, Campbell, 1992; Clements & Myles, 1994; Leidner, 1993; Reiter, 1991; Reskin & Roos, 1990 ; Tomaskovic-Devey, 1993). Despite the mostly negative connotations ascribed to work by contemporary writers, derived from the above frameworks, Collins (1991) observes that there are usually always positive aspects of work, too, even that characterised as lower echelon:

Work as alienated labor can be economically exploitative, physically demanding, and intellectually deadening – the type of work long associated with Black women's status as "mule"....But work can also be empowering and creative , even if it is physically challenging and appears to be demeaning (Collins,1991a; p.48).

The above point was borne out in my previous study of personal care aides (Jamieson, 1996).

Braverman (1974) identified two seemingly contradictory themes in the literature

of industrial sociology: 1) the theme that modern work, as a result of the scientific-technical revolution and automation "requires ever higher levels of education, training, the greater exercise of intelligence and mental effort in general" (Braverman, 1974; p.3); and 2) the other seemingly contradictory theme was the separation of conceptualisation and execution along with the increasing subdivision of industrial and clerical jobs into petty operations. Conceptualisation, he says, becomes the domain of a managerial class, while the workers repetitively perform separate minute aspects of the physical side of production under the surveillance of the managers. The 20th century phenomenon of splitting the labour process into many tasks to make production as efficient as possible has been termed "scientific management", rationalization, and Taylorism.

Taking a different tack from the Braverman thesis, Burawoy (1979) focused on the interaction between workers and between workers and management in his ethnography of a machine shop. Studies in the field of industrial sociology during the 1940's to 1970's, he noted, had usually focused on how to increase workers' motivation by posing the question "why don't workers work harder?" Burawoy (1979), however, began to pose the question "Why do workers work as hard as they do?" or "Why do they participate in their own exploitation?" He conceptualised a continuous interplay between the "spontaneous consent" of workers in the machine shop, combined with varying degrees of managerial coercion that together shaped productive activities within the labour process. The spontaneous consent was seen in the culture of "making out" (that is, making more than the minimum output stipulated by management) whereby individuals evaluated one another and themselves, and formed hierarchies.



This question - "Why do they work as hard as they do?" - is certainly applicable to nurses, and has at least some relevance to hospital hierarchies. Buroway considered that hierarchies of privilege on the floor were reinforced by technology: the more sophisticated machines requiring greater skill to operate, he thought, also had the easier rates. This is opposite to Braverman's contention that automation and technological development of production was correlated with less education, skill, and intelligence from the worker. "Skill", however, as a construct applied to labour is not an easy thing to define (Rauch, 1996). It is often used in collective bargaining as a label to differentiate between different categories of jobs, and rates of pay (Braverman, 1974) and often has a gendered connotation as well, as in the term "skilled labour". Smith (1999) considers that "skill" is a concept used in state accounting and management of the workforce; she states "Categories such as 'skill', 'occupation', 'industry' are constituted in textually concerted organization lodged in the ruling relations - a constituent of state accounting that is part of the management of a labour force" (p. 35). The concept of "competence", used in nursing, might well be an analogous construct.

Marxist labour process theory is quite suitable to guide an examination of the work of front-line nurses in hospitals. It is these nurses who are in daily physical contact with the actual work of nursing. These are the nurses considered by some writers (for example, Campbell, 1988;1992; Coburn, 1988) as analogous to proletarians, or as actual proletarians, in the profession of nursing. These authors cite the concentration of the nursing workforce in hospitals, the routinization of nursing work, and the lack of decision-making power over their own labour process.

Although front-line nurses provide a social service, their work is closer to

professional and scientific work than it is to most other service work. Their proximity to scientific work (for example, medical and pharmaceutical research, as well nursing research) imbues nurses to some extent with knowledge from scientific investigation, although only a fraction of nurses actually take part in that avenue of human knowledge. As discussed in Chapter 5, however, the work of front-line nurses is also closer to other service work than are other hospital professions, even those predominantly occupied by women. In order to explain why this is so, I have had to make use of additional theoretical approaches to complement labour process theory.

Therefore, while I include extensive quotations about front-line nursing work, and descriptions of that work, that are congruent with a Marxist labour process interpretation, I also make use of the writings of feminists in critical social theory and social constructionism. It will be seen later in the chapter that the latter two theoretical strands have commonalities. Moreover, they both overcome limitations of strictly Weberian approaches when considering hierarchies within the nursing labour force.

The analysis by Clement and Myles (1994) of class, class-consciousness, and characteristics of work, combines both labour process theory, and Weberian stratification theories. The phrase in the title of their study "Relations of Ruling" is adapted from Dorothy Smith. Smith (1992; 1999), however, considers that contemporary Marxist theories of class like those of Olin Wright, Poulantzas and Carchedi (who influenced Clements & Myles) are part of the contemporary sociological discourse that tends to obscure rather than clarify. She (1999) states:

classes...mapped out as a structure consisting of categories of persons or positions, where class is objectified in the text in the elaborate theoretical constructs needing rather careful fitting to the actualities of contemporary social relations. (p. 34).

Indeed, with rather careful fitting between the framework of Clement & Myles and the structure of the hospital workforce, some similarities are seen in the various positions in the echelons of each. It is more useful as description, however, rather than explanation.

Clement and Myles (1994) rework the Braverman thesis regarding the division between conception and execution in the labour process, to explain the formation of two layers in the capitalist class: managerial capitalists who have decision-making power over assignment of the forces of production; and those who have executive power that involves exercise of authority over labour. It is not within the scope of the present study to verify whether or not there are similar divisions within the capitalist class from the perspective of front-line nurses, although In Chapter 10, I do refer to a sharp ideological divide at the highest recesses of power. As health care restructuring proceeds in British Columbia, the characteristics of the "relations of ruling" may become more transparent to nurses and others in the health care sector.

Further down the hierarchy of classes, Clement and Myles (1994) state, a new middle class has emerged that includes those who exercise control and surveillance over other employees, or play a role in lower-level management of people and budgets. This would be applicable to front-line nurse managers. The working class is defined here as those who lack command over the means of production, over the labour power of others, or over the employment of their own labour. According to this interpretation, hospital nurses could be considered part of the working class. Interestingly, Clement and Myles observe that female middle managers almost always have authority only over other women, and almost never over men.

### Scientific Management and Beyond

A discussion of labour process theory would not be complete without a discussion of “scientific management” and the contemporary management tactics that have replaced it. Factory owners before the turn of the last century used the strategy of scientific management over the labour process to break the labour process into its component parts, successfully separate conception from execution, and thus facilitate their control over the labour process that was formerly controlled by the craftsperson (Braverman, 1974). Scientific management (also known as “Taylorism”) made possible the advent of mass production or “Fordism”. Scientific management gave rise to a new “class” whose only job was to manage (Myles & Clements, 1994), and to a new field of study initially claimed by the disciplines of industrial sociology and commerce.

The Tavistock School of management in England that replaced scientific management was seen as more humanistic (Braverman, 1974). Rather than managing the workers through force, it asked the question “How can we motivate workers to want to do the job better?” Subsequent trends in management can be seen to have descended from the Tavistock School, including Total Quality Management (TQM), which was initially thought of as a Japanese-derived style of management (Thomas, 1994) when it was first introduced to industries in North America. Much of the literature on restructuring in the early to mid 1990’s focused in part or in whole on the management technique of Total Quality Management (TQM). I selected two examples of studies about TQM from business management literature, and several studies from authors critical of TQM.

Management literature in the mid 1990’s abounds with studies of TQM.

An ethnographic study (Barker, 1993), for example, purportedly documents how a manufacturing company evolved into a "post bureaucratic organization" (echoes of post modernism) through the adoption of TQM principles like "self-managing teams". Barker maintains that the "control system" of the company had moved from Weber's iron cage of bureaucracy based on rule-based rational control, to the concertive control of self-managed teams whose members monitor their own and each others' behaviours even more closely.

Barker (1993) appears to be reading into data the results that he had expected from the conceptual frameworks he started with. He is thus a good example of what Dorothy Smith identifies as inquiry started from a location in established sociological methods and discourse. His conclusion, for example, that the team members "had become their own masters and their own slaves" is not warranted even by the facts that he presents. He notes that although workers reported heightened stress under the new system, "team members are relatively unaware of how the system they created[!] actually controls their actions. It seems natural, and they willingly submit to their own control system" (p. 437). This is reminiscent of Burawoy's conception of game playing and "manufactured consent".

Another management study (Westphal, Gulati, and Shortell; 1997) is an examination of the efficacy of TQM adopted by hospitals in the U.S. from 1985 to 1993. They found variations and "ambivalence" in the effectiveness of this management mode.

Thomas (1994) considers that there are two main forms of TQM as it was adopted in North America: one emphasises continuous improvement and learning at

both the individual and organizational level; while the other trend emphasises routinization of activities. The first form, he says, translates in practice to “unrelenting scrutiny and criticism” in order to bring about “improvements”; while the other results in a “tightening of quality standards without any change in or greater understanding of the processes that lead to quality problems” (p.209).

In the early to mid 1990's, the language of management entered the discipline of nursing, partially displacing what was usually thought of as nursing “administration”. Most writers about new management styles in health care, like TQM, predicted that it would “empower” nurses (for example, Gardner & Cummings, 1994; Perley & Raab, 1994; Sabiston & Laschinger, 1995; Tebbitt, 1993; Wilson & Laschinger, 1994). Other studies and articles, however, are critical of the use of a business style of management in health care. Smith (1999) identifies scientific management (or Taylorism) as a mode of the “relations of ruling” that served to produce standardization between workplaces. She thinks that changes in contemporary management styles, while reinforcing standardization, have disrupted accommodations workers were able to make under previous management styles:

Taylorism [is]...an ideology of management that focuses on the design of work disciplines that will produce in local settings of production a standardization of work practices corresponding to the systematics of the accounting text....Changing accountancy and managerial practices disorganizes and disrupts the accommodations workers have established to give them some control over work processes and relationships (p.89).

Examples of accommodations that nurses have been able to make to some “accountancy and managerial practices” that they did not like, are explored in Chapter 9.

Armstrong, Armstrong, Choiniere, Mykhalovsky, and White (1997) are

prominent critics of health care restructuring, and of TQM, the management style that accompanied it. The application of TQM into the hospital sector was allegedly to facilitate cost containment and better health care, and to result in happier, more "empowered" employees. Interviewees in their studies, however, perceived that they were under increased surveillance through the introduction of "team work" which involved ordinary workers taking on management roles. They reported feeling increased stress. Moreover, the management tactic of TQM did not result in decreased costs, but did result overall in a decreased quality of patient care. Likewise, Campbell (cited in DeVault, 1998) examined the effects of TQM on front-line staff in an extended care facility and also found that it actually decreased the quality of patient care and had a negative effect on working conditions.

In the following section, the focus is shifted from the nursing labour process to interactions among front-line nurses that form part of their working environments. I examine how social constructionism can be applied to the interactional environment of nurses. Interactional environments, it will be shown, cannot be understood from labour process theory only, nor from traditional stratification theories.

### **Organizational Behaviour and Social Constructionism**

Collins (1991a) found Weberian stratification theories insufficient to explain the working locales and experiences of Afro-American women. "Status attainment research has relied heavily on occupational prestige of traditionally male jobs", she states (p.45). Like Collins, I found Weberian-influenced frameworks described (presumably) male criteria for what constitutes desirable or non-desirable jobs, which did not seem to jibe with the situation of nurses. For example, Tomascovic-Devey (1993), who was

influenced by Max Weber and Frank Parkin, lists "power over other workers" as a desirable job characteristic. In the interviews with four nursing managers in the present study, none indicated that this was a desirable characteristic of their job.

Collins (1991a) considers another weakness of the Weberian model: "In the status attainment model, class sorts out positions in society along a continuum of economic success and social prestige" (p.45). The model of prestige associated with economic success would not explain why nurses would choose to work in one level of care over another, for example, when the wages are the same in all the levels. Collins (1991a) also says that in the status attainment model "Social classes become relative rankings and people engage in relative amounts of ascending or descending the ladder of social class" (p.45). Of note here is her observation that people engage in "relative" amounts of ascending or descending the ladder of social class. The model does not explain why only some people and not others ascend or descend the ladder, nor what their motivation is.

Collins (1991a) considers that Afrocentric feminist analyses of Black women's work promises to shed some light on ongoing debates concerning social class. Her discussion of newly emerged classes in Black communities is informative when considering the class divisions within the gender-segregated occupation of nursing. As will be seen, it is particularly informative in illuminating the position of nurse managers (although it only partly addresses the question of why some Afro-Americans choose to become middle class, or why nurses choose to become managers):

The emerging Black middle class occupies a contradictory location in the American political economy. As is the case for their white counterparts, being middle class requires Black professionals and managers to enter into specific social relations with owners of capital and with workers. In particular, the middle class dominates labour and is itself



subordinate to capital. It is this simultaneous dominance and subordination that puts it in the "middle". Like owners, it exercises economic control. Professionals and managers also exercise political controls over the conditions of their own work and that of workers. Finally, members of the new middle class exercise ideological control of knowledge; they are the planners of work and framers of society's ideas (p.60).

Social constructionism overcomes the weaknesses or gaps in traditional stratification theories. The characteristics of social constructionism include (Burr, 1995): a critical stance towards taken-for-granted knowledge (it shares this characteristic with critical social theory); the principle that ways of understanding the world is a product of social processes and interactions; and the acknowledgement that these negotiated understandings take a wide variety of different forms, each inviting a different kind of action. Ross and Nisbett (1991), referring to Lewin as an early "situationist" in this tradition, reword the principles thus:

Lewin's particular concern was the capacity of situational factors and social manipulations to influence patterns of behaviour that normally are seen as reflective of personal dispositions and preferences. The main point of Lewin's situationism was that the social context creates potent forces producing or constraining behaviour (p.9).

A milestone in the history of this branch of thought was the publication of Berger and Luckmann's (1966) *Social construction of reality: A treatise in the sociology of knowledge*. Social constructionism was taken up by numerous researchers in the field of social psychology (for example, Burr, 1995; Gergen, 1998; Parker, 1998; Potter & Wetherell, 1987; Ross & Nisbett, 1991; Willig, 1998) as well as in sociology (for example, Smith, 1990a) and other social sciences.

The tradition of symbolic interactionism preceded social constructionism, and exerts a strong influence upon it. As Ross and Nisbett (1991) point out in their discussion of "situationism" and "construal": "the symbolic interactionists Mead and Goffman discussed the processes by which situational definitions are 'negotiated'

through social interaction" (p.75).

The term "symbolic interaction", coined by Blumer in 1937 (Berg, 1998) but based mainly on the prior work of George Mead, denotes a branch of sociology originating in the Chicago School of Sociology in the 1920's, the main focus of which is social interaction and the symbolic meanings the actors ascribe to it. According to this approach, individuals while interacting with one another are continually evaluating and interpreting self and other, and evaluating the process of interaction itself. The "self" is seen by scholars in this tradition as a result of reciprocal acts of interpretation between interacting partners in a certain historical, cultural and situational context (Blumer, cited in Foddy, 1994). The applicability of this approach can be seen as front-line nurses negotiate the identities of "competent" and "incompetent" on the nursing floor, as well as other identities.

A number of scholars using an interactionist or constructionist perspective (for example, Estroff, 1981; Foschi & Buchan, 1992; Kramer, 1996; 2000; Lemert, 1962; Scheff, 1966; Scott, 1969; Smith, 1990a; 1995; Tudor, 1996) have examined patterns of exclusionary interaction at work sites and other small group sites. This approach is promising in terms of gaining an understanding of how hierarchies and strata are formed and maintained in hospitals.

In his seminal study of the dynamics of exclusion at workplaces, Lemert (1962) draws upon organizational and interactionist perspectives to examine data from interviews with patients and families of patients identified as paranoid. He describes a composite trajectory of aborted communication patterns wherein a person at work comes to be thought of as, and actually becomes, "paranoid", and is removed from the

worksite on that basis.

In his study of first-term MBA students at a major business school, Kramer (1996) argues that group categorization processes (that is, categorizations concerning "ethnic and newcomer status") generate heightened self-consciousness and perception of being under evaluative scrutiny that foster the emergence of "paranoid cognitions" among those so categorized. The personal identity and self-esteem of those categorised is threatened, he notes. In a later study Kramer (2000) identifies "a form of heightened and exaggerated distrust and suspicion of other political actors" in an organization, which he states are closely linked to individuals' beliefs and expectations about other people.

In her meta-study of the socialization experiences of "minority nursing students" Porter-Tibbetts (1992) found that interpersonal difficulties are one of the main sources of stressful experiences among these students to the extent that a high proportion fail. Interpersonal difficulties included "fear of faculty", conflicts with other nursing students, and conflict with nurses on the floors where they did their practicums. Along with perceptions of exclusion from nursing socialization the minority students experienced heightened awareness in the form of "drawing unwanted attention", "sounding different" and "physical visibility" (p.135).

In a small number of nursing studies found (which, however, lacked empirical data), writers influenced by the conceptual framework of Franz Fanon explore the themes of domination and "oppressed group behaviour" among nurses (Hedin, 1986; Roberts, 1983; Thompson, 1987). Nurses belong to an oppressed group, Thompson states, by virtue of their lack of autonomy, accountability, and control over the nursing

profession. As a result, they share certain behaviours with other oppressed groups, like divisiveness and "horizontal violence" or lateral attacks. Roberts (1983) and Hedin (1986) state that similar to members of other oppressed groups, nurses suffer from low self-esteem, self-hatred (which is the internalization of negative dominant attitudes towards themselves), submissive-aggressive behaviour, internalisation of the characteristics of the powerful, and dislike for other nurses.

The above critical studies lack conceptualisation about the interlocking effects of class and racialized ethnic positions within this (gender segregated) oppressed group. With the exception of studies by Campbell (1988; 1992; 1998), who does write about class relations in nursing, this critical scholarship was also found to lack empirical data, as noted above. Studies by anti-racist theorists (Calliste, 1996; Das Gupta, 1996), on the other hand, contained rich descriptions of exclusionary interaction based on racism in nursing. No explanation is offered, however, for the motives of those taking part in racist exclusionary processes. In Calliste's (1996) study, there is a suggestion that targeting may be managers' tactics to control through "divide and rule", but how this is accomplished, and their perspectives or the perspectives of other nurses involved is not explored.

Social constructionism in itself is limited by a lack of class, gender, and racialised ethnic dimensions in the dynamics of interactions it describes. It cannot on its own explain why one "side" in an interaction generally has more power than the other to negotiate identity, interpret the encounter, and decide its outcome. Combined with the two theoretical approaches (critical social theory and labour process theory) described previously, however, it is a valuable tool.

Feminists who write in critical social theory, it has been shown, rely heavily on a Marxist framework, and it is a branch of that tradition that has given rise to “standpoint” research, one example of which is “institutional ethnography” - the strategy informing the methodology of the present study. The methodology and the design of the study are discussed in the next chapter.

In this chapter, I have examined several approaches to the analysis of “class”, and have adopted two main approaches - evident in Chapter 5 when I discuss class in terms of hospital hierarchies, and the nursing labour process. In the former framework, class is associated with concepts like “prestige” and privilege, established and made meaningful during interactions among people situated in different hospitals locations (the influence of social constructionism is evident here). In the nursing labour process framework, on the other hand, class is seen as a function of nurses’ work. Hospital nurses can be seen in this framework as a “proletarian” class whose members do not have control over their own labour process nor that of others. They share characteristics of proletarian work, such as being concentrated in places of work (hospitals), with the work increasingly intensified, routinized, and under close surveillance. In the following chapter is a description of the research method that informs the study – institutional ethnography.

### CHAPTER 3: RESEARCH METHOD

The methodological framework guiding the present study is institutional ethnography. The choice of this research strategy flows from the conceptual framework discussed in the previous chapter. Indeed, it has its roots in the branch of feminists writing in the tradition of critical social theory, who identify with "standpoint" research and theory. The choice of this research strategy also provides a more explanatory potential than other feminist methods might. That is, it suggests a pattern and sequence in the investigation whereby observations during fieldwork can be linked to (heretofore unseen) social forces that are informing the experiences of the people whom one is interviewing. Institutional ethnography has been aptly described as a strategy of research wherein the "direction of the looking is reversed" (Smith, 1986; 1987; DeVault, 1999). Rather than examining a group of people from the perspective of already established categories (which, Smith [1986] contends, is the same as examining people from the perspective of the "relations of ruling" or from "top down") the researcher is examining social organization itself, starting from an entry point situated in the everyday lives of women or other people. While other feminist methods (like oral history, for example) may well give rich descriptions of the everyday lives of people, institutional ethnography takes the investigation further to reveal the interconnections between those experiences and the various aspects of the modes of ruling that have insinuated themselves into the local sites of experience. It offers the possibility of the subjects acting upon phenomena that are heretofore unseen.

Canadian sociologist Dorothy Smith (1986; 1987) considers "institutional

ethnography" as a research strategy rather than a specific method with a specific set of tools. At the same time, she does identify three stages in her and a colleague's research inquiry into the informal work parents do to help their children achieve success in school, and how this work is articulated to and coordinated by the educational system (Smith, 1987; p.181).

In the first stage, they conducted open-ended interviews with 12 women who had children in two different schools (one predominantly working class, and the other predominantly middle class), and asked them to talk about the work they did in relation to their children's schooling. The second stage of research entailed interviewing teachers and administrators in the schools, in light of the interview data of the first stage, to see how the parental work was embedded "in the generalizing social organization of the school" (Smith, 1987; p.183). The third stage of investigation, conducted at the administrative level of the school board, "followed from the first stage of analysis and the organization that became visible at the level of the school" (Smith, 1987; p.185). The present study follows that general pattern of investigation.

Smith (1987) defines "institution" thus:

I am using the terms "institutional" and "institution" to identify a complex of [social] relations forming part of the ruling apparatus, organized around a distinctive function – education, health care, law, and the like. In contrast to such concepts as bureaucracy, "institution" does not identify a determinate form of social organization, but rather the intersection and coordination of more than one relational mode of the ruling apparatus (p.160).

She (1987) explains that the Marxist-derived concept of "social relations" she uses helps to drive the research in a certain direction:

The concept of social relations ..provides a procedure for analysing local work practices – the locus of the experience of the subject – as articulated to and determined by the generalized and generalizing relations of economy and ruling apparatus (p.166).

According to this strategy, the researcher starts inquiry of social organization and social relations from the standpoint of women (or other people) amid the actualities of their everyday work. DeVault (1999; p.28) points out that like the standpoint approach in general, institutional ethnography takes a critical stance. As the research proceeds, it becomes apparent to the researcher and subjects how their experiences are coordinated and regulated by the larger social structures. How the "modes of the ruling apparatus" intersect and are coordinated at a particular site - the "seamless web of polity, economy and ideology" (Collins, 1991a; p.7) - is not at first apparent to either the participants in the study or the researcher (Roman & Apple, 1990; Smith, 1986; 1987).

DeVault (1999; p.28) adds that institutional ethnographers attend to the details of interaction and are always concerned with situational connections, with relations across and among various sites of activity, and with the coordination of these sites via ruling regimes and their texts. Creswell (1998; p.60) and DeVault (1999) consider that institutional ethnography shares with the tradition of ethnography the characteristics of a relatively long period of fieldwork (immersion in the day to day lives of people), descriptions of a culture-sharing group, analysis by themes or perspectives, and interpretations<sup>6</sup>.

I spent over a year immersed in the working environments of front-line nurses by conducting participant observation and in-depth interviews. I started in-depth open-ended interviews with 15 nurses while conducting participant observation on the floors of two hospitals. This corresponds to Smith's first stage of inquiry. I then went on to interview four managers (while continuing with in-depth interviews of an additional 10

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<sup>6</sup> Smith, however, considers that she and her colleague made no attempt to codify the data, identify themes nor to



front-line nurses), which marked the second stage. I also attended a recruiting meeting for a hospital administrator, and a ward meeting where a hospital administrator explained some policy changes. In line with the third stage of inquiry, I looked at diagrams of hospital organizations, read bulletins from hospital administrators posted on the floors where I did my fieldwork, reviewed government publications concerning health care policy, and reviewed management literature pertaining to both hospital nursing and private sector industry. I also reviewed the monthly magazine of the Registered Nurses Association (RNABC) published over a 20 year period and reviewed the B.C. Nurses Union (BCNU) publication *Update* published over a 10 year period.

Although Smith asserts that she and her colleague made no attempt to codify interview data into themes and to interpret it (beyond that which their conceptual framework evoked), she does, in fact, identify themes and makes interpretation of the data - for example, in the use of such concepts as the "monitoring-repair sequence" (1987; p. 206) and the Standard North American Family. I, too, identified themes in the interview data, and developed interpretations.

Anxiety about competence and fear of incompetence was a strong theme that emerged when nurses talked about their work. On exploring the theme further, it was evident that anxiety about competence and fear of incompetence sometimes translated into the targeting of individual nurses in working groups by other members of the working group, on the grounds that individual nurses potentially posed a danger to the patients and to the other members of the working group. Managers were implicated in such interactions. Looking at a map of hospital hierarchy, and reviewing government

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interpret them, beyond that which their conceptual framework indicated.

reports of health care delivery and funding, as well as reviewing management literature helped to provide insights into the greater context in which nurses work.

Thus the problematics of work encountered by front-line hospital nurses provided clues to a potential unfolding of some hidden aspects of nursing work. This in turn revealed an articulation to larger social structures and to relations that control nursing workplaces and that coordinate one site of work with countless others. Nursing work was seen as situated in a health care system that is intricately connected to various industries in health care, and to the judicial, educational and political systems – the “relations of ruling”.

In accordance with the tenets of ethnography, this study contains detailed descriptions of the basic unit or culture-sharing group in hospital nursing - the working group of front-line nurses – along with descriptions of their work, and artefacts in their working environment.

### **Research Design**

The participant observation was conducted in two hospitals in Greater Vancouver - one teaching and the other non-teaching. One purpose for gathering data in more than one hospital was to help provide anonymity for the study participants: nurses in either of the hospitals who had seen me there as a researcher, and who might read the thesis, would not be able to identify which hospital was being described in the thesis. The reason for selecting a teaching and a non-teaching hospital was to detect differences that might have existed between those two types of organisations in terms of the interactive experiences of nurses at those sites. For example, I found that nurses working in smaller “community” hospitals thought that it would be more

prestigious to work in a larger teaching hospital. They often felt slighted by the administration of the larger hospital under which they were amalgamated.

Prior to beginning interviews, a total of 310 questionnaires (see Appendix A) were put into mail folders or slots of registered nurses working in 3 floors or units of each of the two hospitals. The 3 floors or units corresponded to three different levels of care: critical care, acute care, and extended care. (The reasons for choosing these three different levels of care are explained later in the chapter). The questionnaires included demographic questions and some questions about hospital interaction and work experience. The questionnaire and the interview guides had been pre-tested among 10 nurse acquaintances before the fieldwork began, and were revised according to their feedback. The questionnaire provided some broad overall data concerning demographics, the levels of well being among nurses, and some preliminary data about interaction and interactive patterns on the floors. It also served the purpose of sparking interest in the study among potential interviewees. Seventy-five questionnaires were returned, about 50 of them consenting to be interviewed<sup>7</sup>.

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<sup>7</sup> Initially, I intended to conduct a cross sectional survey before beginning the in-depth interviews. Problems with conducting a survey, however, became evident as soon as I began distributing questionnaires in a large teaching hospital. In the critical care area, the nurses' mail folders were contained in a cabinet that was located in a lounge shared by nurses from a number of intensive care units (ICU's) in the hospital, so that there were a very large number of them. This contrasted sharply with the mail slots of the RN's in extended care (ECU), of which there were far fewer. As the completed questionnaires began to come back, it was evident that a much larger proportion of nurses in critical care were willing to fill out the questionnaire compared to those in ECU. In acute care the proportion was less than in ICU, but more than in ECU. The usual reason given for not filling it out was "there have been too many questionnaires". In addition, almost half of the nurses in all levels in whose mail folders I put questionnaires were not at work or did not even pick up the questionnaires. Some were on holidays, were off sick, or on maternity or other leaves of absences. Thus I was aware that to conduct a survey with a representative sample of nurses would be extremely difficult and would involve sending out waves of "reminders" (that had no guarantee of greater success) and contacting nurses through other means. Therefore, unless I had been willing and able to spend a lot of time tracking down enough nurses from each of the nursing floors to make a representative sample, the data obtained could not have been considered a cross sectional survey. I therefore used the completed questionnaires mainly to provide demographic data in choosing interviewees, and as the means to contact a proportion of the interviewees. The completed questionnaires were also very useful, as preliminary data, in guiding me about what questions to ask

An ethical review form from the "University of British Columbia Behavioural Sciences Screening Committee for Research and Other Studies Involving Human Subjects" was completed and approved before interviewing commenced. Ethical review forms from the ethical review boards connected to the two hospital sites were submitted and approved. Prior to contact with the researcher, participants received letters of introduction describing the purpose of the study (Appendix B), how it was to be conducted, and given the choice whether or not to participate. Signed consents were obtained from each interviewee prior to interviews. Each participant was assured of confidentiality, and that she was free to withdraw from the research project at any time. During the collection and analysis of the data, participants were assigned a code name, and work sites were also assigned code names; only I and the members of my dissertation committee had access to transcripts of the interviews. Tapes and transcriptions of interviews were kept in separate locked file cabinets. Participants were assured that tapes would be erased once the study and related publications had been completed.

I next conducted a series of in-depth interviews starting with open-ended questions, with 15 nurses who had completed the questionnaires (and from other sources), and later, with ten more nurses from this and other sources. At the same time, I carried out fieldwork on 6 floors through participant observation, by "buddying" with one or two nurses on each floor for three to four hours a day (or night) for 4 weeks on each floor. These nurses (the interviewees and those I was buddied with) were analogous to the "key informants" in Spradley's (1979) ethnographies: they are

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or what prompts to use, when interviewing nurses.

members of the culture group who have expert knowledge about that culture.

Although there were three identifiable stages in the data-gathering phase of the research, they sometimes overlapped, as did the data-gathering phase and the analysis phase. For example, I had the opportunity to attend a recruiting meeting for a hospital administrator (the second stage) while still interviewing the first nurses (the first stage). Smith explains that by the time the researcher reaches the third stage of data gathering, analysis has already begun. This was the case in the present study.

### **The Setting and the Participants**

The participants in the study were female registered nurses about half of whom worked in two specific hospitals on the Lower Mainland (one teaching and one non-teaching). In addition, a number of nurse-interviewees were working in hospitals other than the ones in which I did participant observation. Interviewees also included four front-line managers (two of whom were former head nurses).

Following is a summary in table form of the numbers of nurses interviewed in terms of the levels of care:

Critical Care	Acute Care	Extended Care
5	11	9

Initially I had the intention of interviewing equal numbers of nurses in each level of care. By the time that I had interviewed the first 15 interviewees, 5 from each level of care, however, it had become evident to me that the acute care level was yielding

themes of interest that needed to be followed up with more interviews in that level.

Indeed, during interviews with nurses in the critical care and extended care levels, issues about acute care were frequently talked about. I thus carried out more purposive sampling for that level. I later carried out purposive sampling in order to interview more nurses with origins in formerly colonised countries (for example, the Philippines) and since most worked on extended care levels, the numbers from that level were higher also.

Of those who received and returned their questionnaires, relatively few nurses working on extended care floors indicated that they would be willing to be interviewed, while almost all those in critical care units indicated that they would like to be contacted for an interview; and more nurses of Anglo or European origin indicated that they would like to be interviewed than nurses of colour from formerly colonized countries. Since I considered the views of the latter very important for the aims of the study, I therefore made use of the snowball method of purposive sampling to contact these underrepresented nurses. I asked interviewed nurses and nurse acquaintances to contact colleagues or friends from the underrepresented areas, and this was successful. Nurses contacted by the snowball method included some from the same hospitals in which I did participant observation, as well as from other hospitals in the Lower Mainland.

Following is a summary in table form of the area of origin of the nurses interviewed:

Area of Origin	Britain	Caribbean	East Asia	Europe	Middle East	Philippines	Quebec	South Asia
No. of Nurses	5	2	3	4	2	5	2	2
First generation immigrant	2	2	1	2	1	4	0	0

Following is a summary in table form, of the ages of the interviewed nurses:

Age	22-39	40 – 55	56 or over
No. of Nurses	12	11	2

Following is a summary, in table form, correlating levels of care and area of origin:

Area of Origin	Britain	Caribbean	East Asia	Europe	Middle East	Philippines	Quebec	South Asia
No. of Nurses	5	2	3	4	2	5	2	2
Critical Care	2	0	0	1	0	0	1	1
Acute Care	2	1	2	1	2	2	0	1
Extended Care	1	1	1	2	0	3	1	0

The three different levels of care – critical, acute, and extended - represent a continuum of greater to lesser “acuity” (sickness) of patients.

After receiving permission from the U.B.C. ethical review board, I conducted a pilot test of the survey questions among 10 nurse acquaintances, and then fine-tuned the questionnaire. For guidance in constructing and administering this survey, I drew upon Foddy (1994) and Fowler (1993). At the same time, I was negotiating entry into the hospitals, after having received permission from their ethical review boards.

Prior to distributing questionnaires, I posted interesting posters in the lounges advertising the potential benefits of the study on each floor/unit where I was to conduct fieldwork, and two cardboard boxes – one for the completed questionnaires minus the front page, and the other for the front page. I then put copies of the questionnaires into each nurse’s mailbox on the floor/unit. Those completing the questionnaire were asked to tear off the front sheet of the questionnaire (The “Introduction to the Questionnaire”), on which they had printed their name and telephone number. On this detached sheet, they indicated whether or not they were willing to take part in one or two follow-up interviews with the researcher, to take place at the place of work, at their home, or at some other agreed upon location.

The follow-up interviews were open-ended and in-depth, taped and transcribed by myself, after each participant had signed a consent form. A set of open-ended questions was used as a guide or prompt when needed: for example, “Can you tell me how you came to work on this floor?” Questions that were asked in the survey were paraphrased, including the question concerning targeting of nurses, how the person came to choose the floor/unit they are working on, and why they have not chosen to



work on the other floors/units. The object was to start to get at processes of exclusion (and inclusion) that the nurse may have encountered or witnessed. "Active listening" during the interviews meant that I was frequently using prompts, paraphrasing, and reflecting. After the first 10 interviews, I began second interviews with some of the first participants, as well as starting initial interviews with new participants. This enabled me to verify emerging themes with the first participants (as well as with members of my dissertation committee) and to clarify points. For example, I was able to ask specific questions about a targeting episode in this way. With subsequent new interviewees, I ensured that I included enough open-ended questions to avoid "premature closure" of emerging categories.

Participant observation on the nursing floors was facilitated through the tactic of "buddying"<sup>8</sup>. On the advertising posters I asked for volunteer "buddies" during my fieldwork. My stated reason for doing the study and requesting nurses to "buddy with" in this phase was that I wanted to learn about the experiences of those doing nursing work in contemporary times in hospitals. I wore uniforms (when interviewing managers, I dressed smartly), and helped out by making beds and fetching items from the supply room. This helped to create a reciprocal relationship between the "informants" and myself (Creswell, 1998), and contributed to building trust, rapport, and immersion in the field. Since these activities actually were a help to nurses on busy acute care floors, I was especially welcomed on those floors (this may not have been the case if I had been a newly hired nurse whom they would have had to orientate). Like student nurses who buddy with experienced staff nurses, I was included in coffee and lunch breaks, in

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<sup>8</sup> During orientation to a floor, a new nurse is usually assigned to "buddy with" a more senior nurse whom

the informal gatherings at nurses' stations that happen intermittently throughout the day, and in nursing unit meetings (including one at which a representative from the hospital administration met with nurses on the floor to announce an impending change in policy). Immediately at the end of each day of fieldwork, I wrote notes in a folder in my computer, including my subjective impressions, while it was still fresh in my memory. Included in the notes were details such as the seating of the participants during informal gatherings and more formal meetings at the nursing station, and the posting of charge nurse status on the assignment board.

During fieldwork, it was important to gain entry or "insider's status" to the ethnographic site (Spradley, 1979; Van Maanan, 1995) so that nurses would trust me enough to talk candidly. Among front-line nurses, there is often a generally concealed disdain for nurses who do not do front-line work, like nurse clinicians, hospital educators, some managers, and those in higher administration. These nurses are seen as having abandoned the physical work of front-line nursing, because it is "below them", and they are often considered to be "out of touch" or even "unsafe" on the floor. There was, however, respect for myself as a front-line nurse bettering herself through education, especially when I made it clear that I was not interested in becoming a manager or a nurse educator. Staff were invariably impressed that I was working on a PhD while at the same time working as a front-line nurse. There was a sense of pride about it, as if it reflected upon them all and showed that nurses are not stupid. One nurse said, "I'm proud of you". My willingness to do physical work on the floors where I was doing fieldwork helped gain me acceptance. When interviewing front-line nurses, I

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she follows around, gradually taking on more responsibilities under her tutelage.

used vocabulary and diction appropriate to the level of care they worked in. When interviewing one ICU nurse who talked quickly, for example, I also talked quickly.

As explained above, however, I had more difficulty contacting nurses from extended care than from the other two levels of care, and more difficulty contacting nurses with origins in formerly colonised countries. To overcome this, the snowball method was useful. This difficulty illustrates that gaining complete insider status during fieldwork is probably not possible, since hierarchical and other differences between researcher and those researched cannot be erased, only acknowledged. My background (of Scottish/Irish origin and a PhD candidate - a class difference), for example, was different to a greater or lesser extent from all nurses who were interviewed.

### **Analysis of the Data**

Interviews were taped and transcribed by myself, and the data from open-ended interviews and field-notes were analysed according to established methods of qualitative analysis (Creswell, 1998; Lincoln & Guba, 1984; Silverman, 1993; Spradley, 1979). Creswell (1998; p.142) describes a "data analysis spiral", with data management as the first loop of the spiral that begins the process. Following this as a guideline, I typed each transcript directly into its own computer file – each interview labelled with the pseudonym of the interviewee. After the first 10 interviews (while continuing with additional interviews), I printed the files out, and read over the transcripts in their entirety several times to "get a feel" for the database as a whole, without attempting any further organization of the data at that time. Next, I identified some initial categories ("major organising ideas"). At this time, memos (ideas, key concepts) were written in the

margins of the field-notes and transcripts, and sentences or paragraphs in transcripts were highlighted with different coloured highlight, according to the emerging categories.

Then, in the “category formation loop”, I employed descriptive detail (description of “what is going on”), classification (identifying 6 general themes and patterned regularities), and interpretation (“making sense of the data”). At this point, Creswell states, the researcher steps back and forms larger meanings of what is happening. Some early themes were: “politics”, fear of incompetence, hierarchy, distress, control, and resistance/solidarity.

Having stepped back, I then recommenced interviewing more nurses, and went back to a number of the original interviewees, with the newly formed framework in mind. I also made return visits to the floors where I had first done participant observation. For me, this whole process took a long time, because often I could not bear to go back and read the transcript excerpts and descriptions, as they evoked in me a sense of “burnout” and distress similar to that of many of the interviewees.

### **The Importance of Reflexivity and the Audit Trail**

Harding (1991) considers that reflexivity is important for “good science”:

A notion of strong reflexivity would require that the objects of inquiry be conceptualised as gazing back in all their cultural particularity and that the researcher, through theory and methods, stand behind them, gazing back at his own socially situated research project in all its cultural particularity and its relationship to other projects to other projects of his culture – many of which (policy development in international relations, for example, or industrial expansion) can be seen only from locations far away from the scientist’s actually daily work. “Strong reflexivity” requires the development of oppositional theory from the perspective of the lives of those Others ... Standpoint theory opens the way to stronger standards of both objectivity and reflexivity. These standards require that research projects use their historical location as a resource for obtaining greater objectivity (p.163).

While it is unavoidable to bring a particular lens or standpoint to the study of social phenomena – as Harding (1991; p.272) says, “We are not blank tablets” – the

imperative is to be conscious of this through active reflexivity. Among other things, reflexivity is the recognition (and documentation) of the mutual impact of the research project upon researcher and "subjects". It is important for validity/credibility reasons (England, 1994; Lamb & Huttlinger, 1989; Van Maanen, 1995), but also, as Anderson (1991) has shown, it can generate insights about the nature of research, power relations, and the nature of knowledge itself.

I kept a daily journal in a computer file (a "reflexive journal") of free-flowing impressions during fieldwork, along with hunches, problems encountered, and dilemmas; from time to time I discussed this and other data with members of my dissertation committee. An example of reflexivity giving rise to insights about the data is illustrated in Chapter 5 where I discuss the dissonance I felt about the term "female dominated occupation". On reflection, I realized that while the term is an inversion of the term "male dominated occupation", it retains the vocabulary of dominance.

During their study Smith (1987) and Griffiths (cited in Smith, 1987) felt dissonance as single mothers. Their feelings of dissonance led them to examine their own roles in perpetuating the widespread conceptualisation of single parent families as "deficient" in relation to the parental work required for their children's success in school, and to their subsequent discovery of the phenomenon of the "Standard North American Family" as a unit of administration in the educational system. I took note in the reflexive journal of occasions when I felt dissonance or when something was odd or "not quite right", and this had fruitful results similar to those of the above researchers. For example, my dissonance with the term "female dominated occupation" led me to identify more accurately facets of the hierarchical context of interactions in the hospital.

There is always the danger of “reading into” data the results that one expects from the conceptual framework that one starts with, or on the other hand, overlooking or missing something. Would I be “seeing” what I set out to see? For instance, would I see processes of exclusion and inclusion, and miss or misinterpret other patterns of interaction that took place? It is not inevitable, however, that a pre-existing conceptual framework determines how one sees and interprets phenomena. For example, although Reiter (1991) started with the conceptual framework of Burawoy when she started her fieldwork at a Burger King outlet, she did not see what she had expected to see – that is, she did not see the manufactured consent and game playing described by Burawoy in his study of skilled machinists on a shop floor. Similarly, I was aware of the phenomenon of targeting before I started my studies, although I had not conceptualised it as such. After a literature review, I did start to conceptualise it, and had a definite framework in mind when I observed or heard about certain interactions that could be seen as targeting, after data collection began. I found, however, that the phenomenon I was seeing was far more complex than what I had come to expect. Indeed, I had to create a new conceptual construct to account for what I was seeing. Thus the researcher is not doomed to merely replicate initial frameworks. Keeping a reflexive journal, and the discussion of data and emerging conceptual categories with members of my supervisory committee was useful in this respect. I also confirmed the emerging conceptual categories with study participants during the course of data collection and analysis. This is in keeping with the feminist standpoint, and helped to ensure confirmability and adequacy of enquiry (Creswell, 1998; Hall & Stevens, 1991). Including frequent and extensive direct quotations from the interview transcripts, along

with detailed descriptions from the field-notes in the write-up, provided rich description. These helped to establish credibility, as did verifying transcripts, shortened versions, and emerging categories with the study participants.

During the analysis stage of the study, it was important to maintain an adequate audit trail (Hall & Stevens, 1991; Lincoln & Guba, 1985; Rodgers & Cowles, 1993), so that readers could see the cognitive processes that I as the researcher went through, and could monitor the adequacy of rationale for decisions and dependability of the research process (Hall & Stevens, 1991). In addition to the field notes, an important part of the audit trail was a record of methodological decisions along with their rationales. I documented this process in a methodological logbook in the computer, and have described methodological decisions in this chapter.

### **Researcher's Background**

As an ethnographer, I did not enter the field as a clean slate, either in terms of my conceptual orientation, nor in terms of my past experience - nor should it be otherwise, for "how can we know the life world of the other except through the frameworks for interpreting the world that we bring to the situation?" (Anderson, 1991; p.116). For purposes of reflexivity, the researcher must acknowledge the framework and past experiences that are brought to the field.

As a practising nurse for 14 years I have an intimate inside knowledge of many aspects of the hospital, and of hospital nursing. Having gone into this profession relatively late, however, this insider knowledge had superimposed upon it my previous experience in many other kinds of jobs, and some theoretical knowledge acquired as a university student in sociology and anthropology. To gain insider knowledge and status

as an insider in hospital nursing over those 14 years required rigorous and often painful processes of re-socialization, during which I often suffered insomnia, anxiety, and at times quite literally feared for my job.

Nevertheless, over the years, I moved from family practice and acute geriatrics to acute medicine; from acute medicine to surgical and cardiac critical care; then to a mixture of extended care in one hospital, and a cardiac rehabilitation program in another hospital; then back to acute surgical and medical care wards. I left each area when it no longer presented a challenge or when I had become too comfortable; but on going to each new area I had to undergo a new re-socialization process. When I had hit what some considered the pinnacle (and plateau) of hospital nursing - critical care – I turned to academia as a form of escape.

Colleagues assumed that I would, through my studies, aspire to leave “front-line” nursing, in favour of some less arduous and more prestigious type of nursing. But a strange bond had developed between front-line nursing and me. There is a sort of addiction to coming home from night shift feeling half drugged from lack of sleep and a “night out of hell” - or perhaps the bond is between me and other front-line nurses who share these conditions.

When I conducted a study of the lives of patient care aides in long-term care, the narratives of these immigrant women of colour struck a chord in me, even though I was peripheral to their working world and to their experiences of racism. The following excerpt from the narrative of one of the study participants probably expresses the dilemma of many women working in high stress/low control jobs (Jamieson, 1995; p. 58): “I have to try to deal with my emotional problem, and it could start from stress



because of things you have seen and can't do anything about".

My previous Master's study was part of a commitment to do something about the conditions in which nurses work, and this present study is a continuation of that commitment. Part of those conditions are that some nurses enjoy relative privilege over others, and make life difficult for others, while most do wonderful work with patients and colleagues despite the sometimes miserable conditions in which they work. The present study must be a tribute to the latter, and enlightenment for the former. The difference between this ethnography and that of other ethnographers (who according to Van Maanen, 1995, continue to visit the sites of their original fieldwork from time to time) is that I do and will continue to have a vested interest in the future of hospital nursing, for I continue to be a practising front-line nurse (on a "casual" basis). In part, then, this study could be considered an "auto-ethnography" – that is, the study of one's own group (Van Maanen, 1995).

## **PART TWO- DESCRIPTION OF THE PEOPLE, THE PLACE, THE WORK**

In the tradition of ethnography, rich descriptions are given of the people, the place and their work. Part Two is mostly descriptive, providing an introduction to the members of the nursing work group and pictures of the immediate environment - the nursing workplace - in which interactions and nursing work take place. Along with an introduction to the members of the nursing work groups and the physical settings, detailed descriptions of nursing work in the three levels of care help to corroborate for the reader discussions in the following chapter about issues in nursing work such as routinization and intensification.

Nursing work is demarcated according to levels of patient acuity, with the three main levels of care being critical, acute, and extended. Each level of care is consigned to specific physical locations, or floors. The demographics of the nursing working groups, in the hospitals referred to in this study, differ from one level of care to another, as does the nature of work, the ascribed meanings of work, and the technologies used at each level. As will be seen in Chapters Five and Six, the nature of work and the different technologies associated with work on different levels of care have symbolic meanings to the members of the working groups, and are intertwined with class, prestige, and ethnic differences between the three levels of care - all of which informs the dynamics of interaction in the working groups. While Chapter 4 is mostly descriptive, Chapters 5 and 6 extend descriptions into preliminary analyses.

## **CHAPTER FOUR**

### **INTRODUCTION TO THE MEMBERS OF THE WORKING GROUP, THEIR PHYSICAL ENVIRONMENT, AND THEIR WORK**

On each floor or ward is a distinct nursing working group, which provides the specific context in which most interactions among nurses take place. The roles in the group are: front-line nurse, manager, union steward, nurse clinician, and unit clerk. Nurses who work on a casual basis are not acknowledged as true members of the working group, although those who return often to the floor and are well known to the members, achieve a sort of quasi membership. Members of other occupations in the hospital, such as doctors, pharmacists, social workers, laboratory technicians ("lab techs"), cleaners, maintenance workers and others, are peripheral to the working group, with varying degrees of distance from or closeness to its periphery. Membership in the working group provides identity to the individual as nurse. She has a specific status within the group, and her membership in the group establishes her status in relation to members of other working groups, and within the hospital as a whole. If she were to meet a nurse outside her working group, or outside the hospital, one of the first questions asked of her would be "What floor (or area) do you work on?"

#### **Members of the Working Group**

Front-line nurses include registered nurses (RN's) and licensed practical nurses (LPN's), while patient care aides (PCA's), who also do nursing work, are not usually referred to as nurses. For the purposes of the present study, I use "front-line nurse" to mean registered nurse. Their dispersal throughout the hospital correlates with levels of

acuity and ages of patients. For instance, on wards with higher acuity (patients sicker), there would likely be more RN's in relation to PCA's or LPN's. In critical care with ventilated patients and heart monitors there would likely be only RN's, though some hospitals may have a LPN or PCA on shift to help with personal care. In extended care, there are few RN's in relation to PCA's who do most of the personal care: washing, dressing, feeding, toileting, changing incontinent patients, lifting, transferring into wheelchairs. This varies among hospitals. On some extended care (ECU) wards, the RN takes a "token" patient to do personal care. On some ECU wards the RN's may do more than a token share of personal care. This is an area of contention in some ECU's, and has implications for relative privilege and challenges to privilege. On an acute medical ward, there may be around 4-6 RN's with one or two PCA's to help with personal care and turns, depending on the number of "total care" patients. If the ward is classified as "sub-acute" (here, the average age of the patients is over 80) there would likely be three or more permanent PCA's or LPN's to do most of the personal care – changing incontinent patients, bathing, helping with eating, helping RN's to turn the patient every two hours.

The length of education for a registered nurse ranges from between 3 to 4 academic years. Until the early 1970's, most RN's were diploma graduates of 3-year hospital school programs and as students, they had lived in nurses' residences attached to the hospitals during their training. These were close-knit groups, whose members often became life long friends. Nurses from that era tell stories of working 12 days or nights in a row and being in charge of entire wards as students. They gained much "hands-on" experience, and usually felt quite confident by the time they were

hired as full-fledged nurses.

In that same time frame, graduates of 4-year university programs (Baccalaureate in Nursing), on the other hand, usually worked as public health nurses, or they became directors of nursing in hospitals. Class differences were evident: usually only women from the middle or upper middle class could afford university tuition, while typically students in the hospital schools, who were paid a stipend, came from farms, from other lower middle class families, or from working class families.

In the 1970's, colleges began to offer two-year diploma programs (that is, 6 semesters) that were extended to three years in the early 1990's. Hospital schools were phased out. When the college programs were two years in length, it was even possible for single mothers on social assistance to get sponsored to go through the programs. Some students worked their way through, or got loans. At the same time, universities began to offer courses toward a Baccalaureate in Nursing by distance (correspondence) and on part-time bases. Differences in class origins were attenuated, while the homogeneity of the age group (formerly 18 or 19 year old high school graduates) was diversified. The former ethnic homogeneity of nursing students in B.C. also diversified. The number of immigrants to Canada from "non-traditional" source countries (Asia, South America, the Philippines, and the West Indies) increased dramatically during the 1970's (Depass, 1992). Job and career opportunities for women also increased during that time, so that women had other options to choose from besides the traditional ones of nursing or teaching.

The formerly homogeneous tightly knit groups in the hospital nursing schools are now a thing of the past. A present day nursing student may elect to take a semester off

and thus not graduate with the students she started the program with. Women with families may now take nursing training, or women who want to change to nursing as a second career.

Licensed Practical Nurses (LPN's) have usually attended a one-year program of study at a technical school, while Personal Care Attendants (PCA's) have attended a 6-month training program in a college or private vocational institute.

It is considered by most nurses that "frontline" nurses do the real work of caring for the patient. They are "with the patient" 24 hours a day, whereas other professionals are not: the doctor sees the patient once a day for a few minutes or half an hour. Dieticians, social workers, and the pharmacist may see the patient once or twice during their stay. Physiotherapists may see the patient more often, perhaps twice a day if needed. The respiratory therapist (RT) may see the patient almost as often as the nurse, if for example, there are problems "weaning the patient" off a ventilator. The (RT) may not actually touch the patient, while adjusting ventilator settings and oxygen concentrations – with the exception, perhaps, of taking a "blood gas" (that is, a blood specimen from the wrist or femoral artery). Only the front-line nurse, however, consistently and around the clock, touches the patient. As the army metaphor "front-line" implies, this is a battle zone, and she (or he in less than 3% of the cases) might very well be in the line of fire and flak – from management, other professionals, other nurses, the families of patients, and patients themselves. The experiences of front-line registered nurses in their work and interactions are portrayed through extensive excerpts from interviews and narratives in Chapters 5 through 8.

After the changeover from head nurses to managers in the early 1990's, front-

line managers were initially called “nursing unit managers” (NUM). The term at present is “patient services manager”, in line with the contemporary management style called “Patient Focused Care”.

Unlike head nurses who were members of the British Columbia Nurses’ Union (BCNU), managers are “excluded from the contract” and have individual contracts with the hospitals. Two managers who made the transition from head nurse said the only difference they noticed at first was that “there were a lot of meetings”. Their jurisdictions expanded to several floors and even to floors of different hospitals. One manager I interviewed was responsible not only for several floors in a large hospital, but also for a floor in a smaller hospital that had come under the umbrella of the larger hospital. In contrast to the head nurses whose level of education was usually no higher than that of other nurses on the floor, most managers have Master’s degrees in nursing, or are studying for their Master’s degree. A few have degrees in disciplines other than nursing, such as occupational therapy, counselling or even commerce.

Union stewards, who are elected to their union position, have “lines” on hospital floors – that is, they have positions as front-line nurses on the floor. They are, however, absent from the floor periodically doing union business, with paid days off (paid by the union) for this purpose. While the union steward is a source of information to other front-line nurses about the specifics of collective agreements, she does not usually represent members of her nursing working group in conflicts with the manager. A steward from another floor, if possible, takes on that role.

Nurse clinicians have Baccalaureate degrees in Nursing. This position was established by hospital administrators soon after the head nurse positions were

deleted. At first they were called "nurse educators" and the role was described as educational resource or support for front-line nurses on the floor, as well as assistant to the manager who no longer had the time to monitor the educational needs of the front-line nurses. Their work activities have included formulating protocols (for instance, regarding the care and maintenance of peripherally inserted central lines) and "certifying" front-line nurses - that is, explaining to front-line nurses and then examining them on certain physician delegated duties such as drawing blood from a central line (this is defined later in the chapter in "Technology"), or removing a central line. Recently they have taken on a quasi head nurse or assistant head nurse role, with titles such as "patient services coordinator/educator". Unlike front-line nurses, they do not wear uniforms, and do not work shifts. Their hours of work, like the manager's, are 8:00 am to 4:00 pm, Monday to Friday. Unlike the managers, they are members of the nurses' union.

In B.C., the unit clerk is a member of the Hospital Employees Union. She (sometimes he) has taken a 6-month course. Although the unit clerk is not a nurse, I have included her as a member of the nursing working group in this section because of her constant and close proximity to nurses and their work. An important part of the unit clerk's job is to process doctors' orders. Often she must locate the nurse who is caring for the patient with the new orders, and inform her if the order is "stat" (urgent), or "now" (not quite as urgent). The patient's chart, with a yellow or blue plastic pull-up flag, is then left on a revolving or moveable chart rack for the nurse to check the accuracy of the transcription. If nurses consider that the unit clerk is always accurate, they will do a cursory check of the orders, but if they consider that the unit clerk is prone to make



mistakes, they will check the orders and transcriptions more painstakingly. New nurses check all orders and transcriptions painstakingly.

Front-line nurses are the only professionals in the hospital who are required to wear uniforms. Dietary, housekeeping, and maintenance staff are the only other employees in the hospital required to wear uniforms. In her discussion of black women working as domestics, Collins (1991; p.57) calls uniforms "physical markers, reinforcing the deference relationship between employers and employees". According to one domestic (Clark-Lewis, 1985, cited in Collins, 1991, p.57) uniforms symbolize that "you were always at their beck and call". Nurses, too, sometimes appear to be at the beck and call of some patients and their families.

Until the 1970's and 80's hospital nurses wore crisp white dress uniforms below the knee, and many wore school pins and school nursing caps. Head nurses wore uniforms, as did the Director of Nursing. Sometime during the 1970's nursing caps were no longer required, and pastel-coloured uniforms began to appear. By the 1980's, pant uniforms were allowed, and white running shoes in place of the white "duty shoe". In the late 1990's, darker coloured uniforms in "scrub" style became popular, in shades of forest green, burgundy, and royal blue. On some wards, younger nurses now do not wear clothing that is recognizable as uniforms.

Most nurses in critical care wear greens or "scrubs". "Greens" are loose cotton tops with a V-neck and short sleeves, worn over shapeless tie pants, originally supplied by the hospital for residents, who sleep in them, and can appear on the floor in an instant wearing them. On acute care floors, the younger nurses typically wear little tight sweaters in various colours, with greens pants, or uniforms they have bought modeled

on the scrub, but in bright dark colours. Older nurses typically wear white or pastels, either dress or pants. On one surgical floor, most of the staff wore their own blue scrub-type uniforms, often with a t-shirt visible under the V-neck.

In extended care most RNs wear street clothes, to help make the facility more like "home" for the residents who live there. Some RN's wear nurses' uniforms – usually dress type. Many of the PCA's in extended care are beginning to wear uniforms – usually pant type, and sometimes greens from the hospital.

Managers do not wear uniforms, but dress smartly and fashionably, as do members of higher management. Nurse clinicians also do not wear uniforms, but their attire is not usually as smart and fashionable as the managers. Members of other professionals like social workers, dieticians, and occupational therapists also do not wear uniforms. The laboratory technician (lab tech) and the phlebotomist (who is referred to as the lab tech but may not necessarily be certified as such) wear street clothes covered by a white lab coat, as do the pharmacists, pharmacist assistants, residents and MSI's.

### **Descriptions and Layout of the "Floors"**

Within the narrower confines of the work station itself - the cubicle, cab, desk, compartment, niche – one can decorate and improvise, become involved in acts of passive resistance, and in a thousand other ways introduce a sense of self in settings that would otherwise seem to exclude it (Erikson, 1990; p.31)

The physical layout of the nursing floors has implications for interactive aspects of work such as surveillance by management, or acts of solidarity among nurses. It is important to describe the physical layout of the hospital floors, to help the reader conceptualise the physical environment in which nurses work, and how it may either impede or facilitate interactions. Reiter (1991) showed how the physical layout of the

Burger King outlet allowed close surveillance over the employees by management and put customers in full view of the employees while they worked, thus motivating them to work faster if they saw long lines of customers waiting. In hospitals, the physical layout of the nursing stations differs from one level of care to another. For example, in the acute care level, patients are not visible to nurses from the nursing station, which helps to promote cohesiveness among members of the nursing workgroup, who interact among themselves without worrying about being overheard.

### Extended Care

The physical layout of the extended care floor indicates the intent to present the space as a "home", despite its obvious institutional setting. The foyer of the extended care building of one hospital I visited is pleasant – fish tanks, large potted plants, a gift shop. Some residents in wheelchairs wait to be picked up by a relative, or watch the comings and goings of others. Some residents with electric battery driven scooters go outside to feed the squirrels, or to visit local shops. Outside is a greenhouse with flowers and other plants. The visitor pushes a button in front of the row of elevators in the foyer and after what seems a long time, an elevator car arrives. After ascending to one of the floors, the visitor steps out and notices that the scene is more institutional than the foyer. There are long hallways, a large dining room with a few armchairs here and there, and many long tables upon which are vases of artificial and real flowers, large windows overlooking trees and buildings, residents sitting in wheelchairs or geri chairs. A large TV is at one end of the dining room. One or two residents may be calling out "Hello, hello!"

At mealtimes, each resident sits in a wheelchair (or occasionally, a real chair) at

an allotted spot at one of the tables in the dining room, awaiting the arrival and unloading of the meal tray carts from the dietary department. The tables are designated by staff into three categories: "one at a time", "total feeds" and independent. At the "one at a time" table, one staff member (either a PCA or RN) supervises the residents there, presenting them items from the meal tray one at a time, while assisting or coaxing some of them to eat. At the "total feeds" table, two or three staff members (RN's and/or PCA's) sit beside residents in their wheelchairs or geri chairs, feeding them with spoons. This is a slow and lengthy process for some residents, and staff members chat among themselves while waiting to give the next spoonful of food. At the independent tables, residents eat independently after the tray is "set up" for them – lids opened and meat cut if necessary. About one-third of the residents do not go to the dining room, but are fed in their rooms in bed by PCA's. A few residents eat independently in their rooms.

On the nursing station counter in the morning are delivered newspapers with residents' names on them. A microphone sits on the counter at front through which the unit clerk or RN (or PCA during evenings and weekends) makes overhead announcements such as "Team two - white light in Room 222", and "The meal trays are here". Announcements throughout the whole building are occasionally heard, such as "There will be a service in the chapel today at 2:00". A large chart rack takes up one wall, while a filing cabinet takes up another. Unlike the nursing station of an acute care floor, patient/residents often wheel into the extended care nursing station through the small saloon-type swinging doors meant to discourage them. Most who do so are confused and wandering, while some are invited in to use the telephone. Opposite to

one side of the nursing station is the glassed-in manager's office, where the manager may be seen working at her desk or interviewing a staff member.

In one facility a small room near the elevator served both as a lounge, and as a place to put coats and was frequented by both nurses and PCA's and even a cook, who all shared food and conversed – it seemed a happy place. In another facility, there was a room at the end of a hall (an activity room during the day), which served as a lounge on evenings and weekends for PCA's, while RNs went elsewhere on their own. On weekdays, people went to a common lounge on another floor for their breaks.

### Acute Care

The centre of the acute care ward is the nursing station which on weekdays is usually crowded with nurses, student nurses, residents, house staff, interns, consulting physicians, physiotherapists, a social worker, an occupational therapist, pharmacist, dietician, home care liaison nurse, and more. During the day, hospital personnel inside the station may be seated at the computers, scrolling up and down for lab results, sitting at the table reading patient charts, or conversing in little groups, while others come in and out of the station. On the weekends, evenings, and nights, nurses claim the station as their own. The nursing station is then sacrosanct. Visitors and patients are discouraged by body language or actual requests not to cut through the station to get to the other side of it, or to enter it to talk to their nurse. The protocol is to wait at the desk until someone notices and offers help.

Pots of flowers and ceramics, left by patients who have been discharged or who have died, adorn the top of the half-wall or ledge that marks the boundary of the nursing station. Inside the station a revolving chart rack displays thick binders holding patient

charts. The phone where the unit clerk sits rings frequently, and she calls out "Did anyone put in a call for Dr. so and so?", "Who is the nurse for Patient X?" On a shelf that extends around three sides of the station there is a fax and printer, several other telephones in frequent use, and one or two calculators glued to the shelf. In the numerous shelves in a high cupboard on the wall are stacks of forms and papers: flow sheets, fluid balance sheets, activities of daily living (ADL) sheets, vital sign sheets, neurological check sheets, sheets for nurses' progress notes, and many more. A green chalkboard on the wall lists patients, along with the responsible staff doctor and resident (newly graduated physician taking further training in a specialty), and alongside that, the nurses assigned to the patients. On the right lower corner of the board the name of the charge nurse for the day is posted, and sometimes a happy face. A doorway leads to the "med room"(medication room) and the clean utility room, where some nurses sit at a table charting, preparing IV bags and tubing on poles, or pouring medications. In the middle of the nursing station are at least one table and many chairs around the station. From the nursing station one can look a long way down the hall and see another nursing station in the distance, with people moving about. The border between that ward and this one is a specific patient room number half way down the hall

From around the hubbub in the nursing station radiate the hallways lined with doors to patient rooms. These are usually always open unless the patient is on reverse isolation, or something important is going on – like inserting a central line, a medical conference around the bed, or transferring the patient with a mechanical lift. Lights above the doorways indicate a patient has put on his/her call bell - the nurse or the unit

clerk flicks a switch on the intercom to the patient's room to find out what the patient wants. The patient's voice, magnified by the intercom, along with background noises in the room – the humming or beeping IVAC, people talking, a radio or TV – resounds throughout the nursing station as the patient makes a request for a bedpan, a drink of water, or announces that the IVAC is beeping. A small telephone from the ICU for the telemetries is attached to one wall or post. It has a higher-pitched ring, which sounds frequently. On the wall of the station near the cupboard with papers, is a square blue "code" button to push when a patient "arrests". Close to the nursing station is the report room, where nurses used to tape change of shift reports, but now has a futon that night nurses sleep on. In comparison to the nurses in the extended care units, the nurses in the acute care floor walk quickly, move quickly, and even talk quickly, especially in the morning or in the first several hours of the night shift.

A nursing lounge adjoins the ward - a converted patient's room. In it is a TV, radio, lamp, futon or couch, small fridge, sink, easy chairs, table. Nurses go there to eat their meals and sleep on their breaks at night. The manager's office may be around the corner from the nursing station, or on another wing or floor. For those who did not bring their lunch, or who do not want to go to the nursing lounge, a cafeteria affords an opportunity to leave the ward during breaks. A few nurses go outside to smoke, gathering and chatting with other pariah-like smokers on benches in front of the Emergency Department, or outside automatic-locking side doors that they hold open with one foot or a package of cigarettes. Smokers appear to shed class, ethnic and gender differences in status during that time. On the weekends or afternoon shifts, some nurses go to a nearby restaurant for meals. Nurses in one ward regularly go to a

nearby restaurant for breakfast on the first coffee break.

### Critical Care – “The Unit”

While acute care and extended care levels are referred to as floors or wards, the critical care site is usually referred to as a “unit”. While in acute care and extended care wards, the nursing station is the hub of ward activity and interaction among RNs, this is not the case in critical care units. In CCU’s and ICU’s, most nurses, especially if their patient is a one-to-one, constantly sit in front of the patient room, typically in front of an “over bed table” holding the patient’s critical care flow sheet, the chart, the nurse’s stethoscope, calculator, and food to munch on or a drink. Over bed tables are small rectangular roll-up or down tables that in acute care wards usually hold a meal tray, or a wash basin, or sundry other items – magazines, food that visitors bring, flowers in vases or pots, hairbrush. In critical care most patients do not get a meal tray if they are intubated or are too sick to eat. Huddles of green-suited residents confer in low voices around the over bed tables with the respective nurses.

Usually, all the patient rooms, which have glass walls and sliding glass doors, are visible from the nursing station. At least one nurse and a unit clerk are at the station at any one time. One nurse is assigned to watch telemetries and the monitors. Sometimes this nurse may also have an assignment and when the alarms ring she flits back and forth to check the screens.

Not far from the unit is the nursing lounge. It has couches, easy chairs, a TV, which is usually on, a microwave, a fridge, a sink, a table, a bulletin board, and some filing cabinets. One nurse lies on the couch watching TV, another one lies with eyes closed, two others sit on the chairs eating out of Tupperware containers and chatting.



## Technology

In the following sections, the use of technology on floors in the three levels of care is described. The level of care most identified with technology, in peoples' minds, is critical care. While technologies are also used on the other levels of care, they are not associated there as much with medicine. This has ramifications for the symbolic meanings of the different technologies, a discussion of which follows in Chapter 5.

### The Technology of Critical Care

At the entrance to the ICU are two red metal "code carts" (these are workshop carts, the kind you could buy in Revy's or Home Depot), with small sliding drawers holding drugs in preloaded syringes, endotracheal tubes ("ET tubes") - inserted into a patient's trachea before attaching him/her to a ventilator, and a large drawer underneath holding an ambubag - a football shaped rubber bag that is manually squeezed to force air into the throat or the ET tube of a patient who has "coded". A "code" or "code blue" means that the patient has "arrested" - they have stopped breathing and/or their hearts have stopped pumping. On the top of the carts are defibrillators and a portable suction machine. Defibrillators are used to shock the non-functioning heart back into an electrical pattern that makes the heart pump effectively again. This, again, is a fairly simple technology: there are stories of some individuals in the community (retired doctors) having used wires in electrical sockets to resuscitate loved ones.

IV drugs that cannot be given to patients on the acute care ward, such as nitroglycerin and dopamine infuse into the veins of patients here, and the vital signs of those receiving these drugs are checked at least hourly. Nurses here may give drugs by

"IV push" (that is, injecting a drug directly into the nearest port of a patient's IV) that only a doctor can give on the acute care floor.

Screens or "monitors" above the patient's bed and in the nursing station simultaneously and continuously display the electrical activity of the heart, arterial pressure, and other measurements such as oxygen saturation (a measurement of what percentage of red corpuscles flowing through a capillary in the finger are loaded with oxygen; this is obtained through a little light fixture on the patient's finger). Electrode pads on the patient's chest are connected to a sensor that records the electrical activity of the heart and sends it to the monitor in a graphic illustration of the heart chambers filling with blood, and then squeezing it out.

Another bank of screens at the nursing station allow the nurse there to also monitor the electrical activity of patients on the acute care floor who have telemetries (little boxes containing electrical sensors attached to electrode pads on the patients' chests; the pattern of electrical activity of the heart is transmitted from the patient to the ICU via a series of small electro-sensitive rods hanging down from the ceiling of the acute care hallway).

The flat counter-like surfaces of the portable ventilators (about the size of a portable dishwasher) have numerous dials by which the volumes of air, the number of breaths per minute, and the oxygen concentration are controlled. They are sometimes called "breathing machines" by nurses when they talk with laypeople visiting the patient. The Respiratory Therapist (RT) visits frequently to monitor the patient and the machines, and responds when called by nurses who have a problem with a machine. At some facilities where the RT is not available on night shift, the nurses are responsible

for attaching the patient to the machine and monitoring it. Otherwise, if things are stable, the nurse checks the ventilator settings once an hour and notes them on a flow sheet along with the patient's vital signs. On the wall are oxygen and medical air outlets, and lower down, fixtures and brackets with suction bottles.

Thus the main technologies that separate critical care nursing from acute care are: (1) certain drugs administered by nurses in this area that only physicians may give on acute care floors, or that may not be given at all on acute care floors; (2) monitors that display the electrical heart activity of patients both in ICU and on the wards (monitors often display other signs such as blood pressure); (3) physician-delegated tasks such as resuscitation and cardiac outputs; and (4) ventilators.

#### The Technology of Acute Care

The intravenous catheter (IV) is one of the technologies specific to acute care in relation to extended care. About one-third to one-half of the patients on an acute care floor typically has IV's running into peripheral veins on the arm, or less frequently, into central venous catheters (CVC's) in the neck or groin. Nurses working with CVC's must have taken and passed a special "in-service" (short course) given by the "nurse educator". IV fluid flows by gravity or through dispensing machines (referred to by their trade names, such as IVAC) from bags hung on poles that the patients push along in front of them when walking to the bathroom or in the hallway.

Some patients unable to take food orally (for example if they have a flare-up of Crohn's disease) have parenteral nutrition: one huge bag of yellow fluid with minerals, vitamins, electrolytes, and protein, and a smaller glass bottle of white lipids infuse into a central line, through an IVAC. Patient controlled analgesics (PCA's) are found on

surgical floors, and less frequently on medical floors in acute care. The PCA machines restrict and record how much morphine or Demerol the patient is taking. The machines are unlocked at 6:00 pm each day by the nurse, "cleared" to zero, and then locked again. On the wall behind each patient bed there are oxygen and medical air outlets, and lower down, fixtures and brackets for suction bottles.

About 6 to 12 cardiac patients on medical floors may have telemetries. Telemetries in rooms near a malfunctioning transmitter in the ceiling, or in a room distant from a transmitter cause alarms to go off frequently in the ICU, necessitating the ICU nurse to alert the nurse on the ward. The floor nurse must then run back and forth to the patient checking lead placement, putting in new batteries, and phoning the ICU nurse each time to ask her if the patient's monitor is still alarming. If everything has been tried, including changing to another telemetry, and alarms are still sounding in the ICU, then the nurses will conclude that the transmitter in the ceiling is malfunctioning, or the room is too far from a transmitter. The patient is moved to another room near a functioning transmitter.

In the clean supply room adjoining the nursing station is a basket for code blues (a dreaded event) – it contains an orange cone to show the code team which room to go to, an ambubag, oxygen mask, medications, and a code record. On the wall behind every patient bed and in the nursing station is a button to push that triggers a siren-like alarm when a patient arrests, signaling the ICU "code" nurse to run to the ward pushing the red code cart.

While all patient beds in the ICU are electrically operated, only a fraction of beds in acute care are electric (except in some facilities that use only electric beds).

Caregivers can lower or raise the head of the electric bed with a push of a button. Beds that are not electric require manual cranking up and down using a crank at the foot of the bed to elevate or lower it. Many nurses report wrist injuries from this activity.

### The Technology of Extended Care

While nurses in extended care do not work with IV's, "sub-q butterflies" are commonly used for dying patients, as they are on palliative care floors also. These are small needles inserted by the nurse into the tissue under the patient's skin, and affixed there with two plastic wings that are taped to the skin. Nurses use them to give morphine or other analgesics, or other drugs to patients who can no longer swallow fluid or pills.

Kangaroo pumps on poles are used to deliver liquid nutrition enterally (that is, directly into the stomach of the patient). Cans of liquid such as "Jevity" and "Ensure" are poured into the bags at specified intervals and delivered to the stomach through tubing that is threaded through the machine, and then attached to the patient's "J-tube" (jejunostomy tube) or gastric tube. This is a short rubber or soft plastic tube protruding from a hole surgically created in the patient's upper abdomen.

There are myriad wheelchairs in extended care, many of them custom fitted by the Occupational Therapist (OT) with special curved insets to fit the contours of residents whose bodies are contorted with arthritis or contractures. Some of the wheelchairs are battery operated, and are plugged into electrical outlets at night.

At the end of one long hallway are a pair of long metal parallel bars on a wooden walkway, with a mirror at the end, where some residents practice walking in the morning with the aid of a physiotherapist (PT). A specially constructed tall walker with a

semicircular padded armrest for the resident to lean on is also used by the PT for those who are not up to using the parallel bars.

As in the ACU, a proportion of the beds are electrically operated; that is, the resident (if mentally and physically able) and the caregiver can raise or lower the bed or the head of the bed with a push of the button. Like the nurses in ACU, many PCA's report wrist injuries from manually cranking non-electric beds up and down.

For heavy residents who cannot weight-bear reliably or at all, PCA's use pneumatic mechanical lifts to transport them from the bed and into wheelchairs. At the head of each bed is a large poster prepared by the PT, OT and admitting nurse, listing what kind of assistance the resident needs with "activities of daily living" (ADL's). These include instructions on how the resident is to be transferred, how much help they need with eating and washing, and how often they should be toileted. In the bathtub room special plastic stretchers lower residents into elongated bathtubs with whirlpool options.

Like everywhere else in the hospital, there are computers in extended care. One is in the nursing station to read lab results, and send dietary orders and give admission information. Another computer in a small room opposite the nursing station is used to update nursing plans for each resident.

In the clean supply room adjoining the nursing station are some portable cylinders of oxygen; there is one room that has an oxygen fixture on the wall. Also in this room is a basket for code blues, which are rare in the ECU since almost all the residents have been designated as "no code".

### **Who Does What Work?**

Front-line nursing work is both officially and non-officially assigned to different categories of nurses, though all bear the same designation of "general duty nurse". It is officially assigned according to hospital policy on the basis of requisite qualifications, and according to collective agreements on the basis of negotiated job descriptions. Unofficially, in hospitals in Vancouver and the Lower Mainland, it may also be demarcated along racialized ethnic lines. Some factors in the unofficial allocation of nurses to different work areas include outside structural determinants, such as credentialing procedures, language proficiency tests, pension plans, and the Live-In Caregiver Program of the Immigration Department. Other factors may include stereotypes that affect performance expectations, personal preferences, life situations, and other factors both within and without the hospital, that are not so easily identifiable. The visible demarcation of work by racialized ethnicity and age, as I observed it, is described later in this section. Chapters Five and Ten contain a more in-depth examination and analysis of the unofficial allocation of nurses to different levels of care.

Each floor or ward has a large binder titled "Procedural Manual" with a list of nursing tasks and how they must be performed according to hospital policy, and by whom (this is now in computers). Another binder from Pharmacy (the binder is referred to by nurses as "the Bible") lists medications and specifies how, where and by whom these can be administered: for instance, on an acute care floor, only a doctor may administer certain drugs by "IV push", while in critical care a nurse may administer the same drug; some drugs may be administered only in critical care and not on other floors.

The respective responsibilities of nurses at each level of care – what each is allowed to do according to hospital policy - are rigidly demarcated. RN's, after special training or special "in-services", can do some "doctor delegated" duties – duties previously the sole domain of doctors, such as inserting IV's, taking blood gas specimens, taking out central venous lines, and ART lines, measuring cardiac outputs through Swan Gantz catheters, initial steps of cardiopulmonary resuscitation, interpreting and recording telemetry readings. Most of the "physician delegated" tasks can be performed only in a critical care area by RN's who have taken special critical care courses, and have then been recertified annually through tests. Relevant here is the "poaching" by one profession into the territory of another profession, described by Abbott (1988).

Some tasks like inserting IV's and taking out central line catheters, can be performed on an acute care ward by RN's who have been certified through a short hospital course. In some wards, LPN's do some work previously the sole domain of RN's, such as inserting urinary catheters, changing dressings, taking vital signs, "charting" in the patient records, and recently, giving medications on some floors. LPN's who do tasks previously the domain of RN's, usually work on wards where this arrangement has been worked out as hospital policy, and there are about equal numbers of RN's and LPN's on each shift.

An RN working in an ECU has the responsibility for one or two "wings", each wing containing typically around 20 patient "residents". She is technically "supervising" the PCA's, and it varies from RN to RN how literally she takes that responsibility. From the point of the view of PCA's, some RN's carry out rigorous surveillance – "always



watching, looking, and spying" (Jamieson, 1996) as though they don't trust the PCA to do their work. Such RN's are disliked by PCA's, who may have derogatory "nicknames" for them, like "Misery". From the same study, some RN's (often the same ones) are considered "lazy" because they do not answer call-bells, or help with transfers, but "just sit at the desk all day talking". Other well-liked RN's do answer call-bells and offer to help with transfers (which is usually refused, though appreciated) and show respect for the PCA's knowledge and skill.

The most time-consuming duty of the extended care RN, which seems central to her day, is "giving out meds". The main times for dispensing medications are in the morning (around breakfast time), and in the evening (around bed time). She also checks and changes dressings on her team, pulling the "dressing cart" down the wing, loaded with tape, gauze, numerous commercially prepared dressings, bottles of Normal Saline, dressing trays, treatment ointments, etc. Each resident who has a wound has a page (a "skin sheet") in a binder on the cart on which is a hand-drawn picture of the wound, and categories describing condition of the wound.

Another time-consuming duty that some RN's feel is stressful, is "admitting a resident" – which requires a lengthy form to be filled out assessing all aspects of the new resident. Other charting, that the team leader is responsible for, is a monthly assessment of the resident. All other charting is done only as needed – a significant change in the resident's condition, a fall, something out of the ordinary. Weekly "interdisciplinary" meetings must be prepared for, as well. When the doctor arrives (either at the RN's request to examine a patient, or to find out "if anybody needs anything"), the RN responsible for the patient in question spends some time talking with

the doctor. The interaction between doctor and RN in ECU appears mutually respectful; this supports the perception of ECU RN's who filled out the preliminary questionnaires that I sent out before doing participant observation.

An RN on an ECU may wash and dress one resident while the PCA's are responsible for the personal care of the rest of the residents – on day shift, there would be around 3 or 4 PCA's on each wing. During the shift and at the end of the shift, the PCA's are expected to report problems to the responsible RN, such as impending skin breakdown. Around 2:00 pm each RN and a small cluster of PCA's sit down in the nursing station to "give report"; the RN then tapes report for the next shift. Recently, RN's on extended care floors (and sometimes on acute care floors) have taken over the doctor-delegated function of "pronouncing death" if the patient is a no code and the death was "expected".

As mentioned previously, the tendency to allocate work in hospitals in Vancouver and the Lower Mainland according to racialized ethnicity is not officially sanctioned by hospital policy, nor is it rigidly demarcated. It first came to my attention at the beginning of my studies, as I walked around the different floors of hospitals from one level of care to another, and also looked at the names on the staff lists on each floor. I noticed that most of the nurses and almost all the Personal Care Aides (PCA's) in extended care levels are women of colour from previously colonized countries. The registered nurses who are not women of colour are typically in their 50's, and some in their 40's. In my study, most younger RN's in ECU are mainly Chinese or Philippina, and a small number of RN's of various ages are African, Caribbean, or South Asian.

On arriving on the floor in the morning, nursing staff members greet those who

are leaving shift or arriving. Diamond (1992) notes that there is a festive atmosphere at this time. The RNs count the narcotics in the med room, chat with each other, and linger in nursing station. A staff member puts on coffee if night shift has not done it. PCA's head for the conference room to wait, chat with others, and sign-in on the payroll sheet. The RNs then arrive in the conference room, select their appropriate team worksheets (with the lists of residents on their team) from the piles on a shelf, and sit on one side of the table. The PCA's sit on the other side of the table and in chairs behind that. Everyone listens to the taped report of the night RN, and then slowly, sometimes reluctantly, goes out to the floor to begin the day's work.

A nurse sits at a table with PCA's for report around 2:00 pm. When tasks are usually completed for the day, PCA's sit there and chat for a while if on weekends, while on weekdays they are more likely to be found in a room talking with each other or with a resident. On some extended care floors, RNs do not do any "Activities of Daily Living" (ADL) work, while on other floors each RN may take a token resident to wash, dress, and get into a wheelchair. In one facility, the RNs did almost as much ADL work as the PCA's in addition to giving out medications, doing dressings, and running tube feeds. All RNs helped with total feeds at mealtime.

In acute care, I noticed that the demographic composition of the nursing working groups tends to vary with acuity. In the Family Practice, Acute Geriatrics, and palliative care wards, for example, there are more nurses of colour with origins in previously colonized countries than in the highly acute ward(s), where the majority of staff members are of Anglo/European origin. This also has some relation to technology (discussed below). Except occasionally, there are no PCA's on the most acute ward

and the RNs therefore do all ADL care. On some floors, they also stock patient rooms with drinking cups, mouth swabs, straws, cardboard emesis basins, and also stock small linen carts outside the patient rooms.

My first impression upon entering a critical care unit in a large tertiary hospital at shift change was of a wave of whiteness. Almost all the nurses sitting in front of the patient cubicles giving and receiving report were of white Anglo European origins. At regular intervals, the nurse gets up and does ventilator and vital sign checks and empties the urine bag and records the output. At less frequent intervals she may do cardiac outputs, blood gases (if it is the weekend and the RT is not available) and chest physio (if the PT is not available). She may get up to give an IV analgesic or sedative. She makes notes in the chart at least every hour. Usually a complete bed bath is given on nights, unless the patient has diarrhea from the tube feed or from lactulose (given to those with liver cirrhosis), at which time nurses from neighbouring cubicles must give a hand to help turn and hold the patient over.

Thus to summarize the findings in this chapter in terms of racialized ethnicity<sup>9</sup>: In the critical care floor of the large teaching hospital where I did fieldwork, most members of the nursing workforce were of white Anglo European origin. In the smaller community hospital, a few of the critical care nurses were Philippina. In the extended care floors, the majority of nurses were of Philippina, East Asian, or South Asian descent. A few were from Africa or the Caribbean and a few of Anglo European origins. On acute care floors, this varied from floor to floor, mostly correlating with acuity of the patients. In

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<sup>9</sup> These findings about the dispersal of nurses in hospitals in Vancouver and the Lower Mainland according to racialized ethnicity are observational. No statistics were found regarding this issue. It is an area for possible future study.

"sub-acute" areas such as palliative care, or in areas where elderly patients predominate, the demographic composition of the working groups resembled that of extended care. In highly acute care floors where patients were on average younger, and where technologies like central lines and telemetries were used, the nurses were predominantly younger and of Anglo European origins.

## **CHAPTER FIVE: CLASSES AND HIERARCHIES IN NURSING WORK: PERSPECTIVES OF THE PARTICIPANTS**

### **The Hospital Hierarchy**

"I don't know who makes that decision, because it's confusing who decides what and who's the boss, and who is the boss over the bosses. It's such a maze of contradictions and confusion" (Iris, ECU).

A "map" of the authority structure of administration in one hospital is shown in Appendix C, which resembles a rather flattened out bushy tree. Lines joining squares in a lower level to a square in a higher level shows the level of command, from lower to higher. An individual located in one of the squares would express the level of command in terms of to whom he or she "reports". The titles of the positions in this authority tree change frequently. A decade ago, a head nurse would report to the Director of Nursing (DON), who reported to the Medical Director. Nowadays, a front-line manager (originally known as Nursing Unit Manager [NUM], then Patient Services Manager) may report to a Patient Services Leader who reports to a Vice President of Hospital Affairs.

Although administrative structures may have flattened during restructuring, the perception of front-line nurses is that they have increased in size, as shown by the following comment by Ellen, a critical care nurse in a large hospital, who was talking about the differences between head nurses and managers:

Probably not an awful lot different except that you saw them more often. I just think that the hierarchy has got bigger. They go to more meetings and whatever than they used to, so they're not always quite as accessible. I just think the bureaucracy's greater than it used to be. You know, there's more committees, more whatever as time goes on.

During one week of my fieldwork I was able to attend a series of meetings during a brief period of what I call "democratization" of the administrative process. The

objective of this series of meetings was to interview candidates for and choose a new assistant to the Patient Services Leader (PSL). The Patient Services Leader had introduced the unusual step of including front-line nurses from various floors to be part of the "selection committee". I noticed that some front-line nurses addressed this person with familiarity, by her first name, and one even made a joke to her. I noted in my fieldwork diary that one of the candidates for the position witnessed the joke and appeared surprised by it. (On the subject of "joking prerogatives", one of the managers I interviewed said that she thought it was inappropriate for a subordinate to tell jokes with her). About a year later, I read in a bulletin circulated to floors in the hospital, that there was a "goodbye" party being held for this PSL who was leaving. The newly hired assistant also left around the same time. The democratization movement had apparently not lasted for long.

Usually, members of the administrative staff are not visible to the front-line staff. Their offices are located in an area of the hospital rarely frequented by any front-line staff other than housekeepers, or by dietary staff taking trolleys with coffee, tea, sandwiches and pastries to a meeting in the boardroom. As the opening quotation illustrates, and interviews with managers confirm, decision-making power is mostly hidden from the view of most staff members, even from the front-line managers.

Occasionally, hierarchy is officially suspended and made light of during a temporary reversal of roles. For example, at a Christmas party for all staff held in one hospital, managers stood behind tables, smilingly serving food to the staff. During a union job action at another hospital a member of higher administration filling the role of "stat messenger" (a porter who responds to requests to transport things quickly, such as

blood gas samples) wore a funny cap with the red letters "STAT" written on a little flag stuck on top. The humour accompanying the role reversal accentuates its incongruity in the minds of front-line staff, and probably in the minds of members of administration as well, which in turn, underlines the legitimacy of the hierarchical positions.

The decisions of higher administration are sometimes challenged, as illustrated in this comment by Ellen:

And we've had to fight to keep them [assistant head nurses]. I don't think in the new administrative environment that they actually think assistant head nurses are worthwhile. And I think they are. Because you need some consistency. I think it was just the hospital management, figured that they were out of vogue. Things have changed a lot.

The above quotation also illustrates that nurses in the critical care level may have more power to influence decisions made in higher administrative levels than do nurses on other levels of care.

### Physicians and Front-Line Nurses

The most obvious and studied hierarchical difference in hospitals is that between nurses and physicians. Nursing leaders and authors in nursing literature have characterized the traditional relationship of nurses to physicians as "handmaidens" (for example, Melosh, 1982) - analogous to the head housekeepers or mistresses of Victorian households, with authority over more subordinate staff, while the doctor is likened to the head of the household. Some older nurses told me that nurses used to stand when doctors came into the nursing station, and had to give them preferential access to elevators.

In the past, most doctors were male. Today, there is more diversification in medical school applications and admissions so that approximately 50% are now female (Beagan, 1998). Concurrently, there seems to be a less rigidly defined class difference



between nurse and physician. As Dina said "It used to be that nurses never questioned a doctor's order but these young nurses think they have the right to do so". As discussed later in this chapter, nurses now routinely perform tasks and procedures previously considered the sole domain of the physician. In terms of salaries, however, there continues to be a stark difference (BCNU, cited in Fuller, 1992).

On a teaching acute care floor, about half of the Medical Student Interns (MSI's) and Residents are female. About one-third of the staff doctors on both medical and surgical floors are female. While the MSI's are there only briefly, the residents are there usually for 6 weeks for their first rotation, and then may return for a second longer rotation later. Thus the nursing staff gets to know them better, and usually relations are cordial and friendly. A well-liked resident finds his or her rotation much easier and less stressful than one who is not liked. Ranjit quoted her friend from high school who is now a medical resident: "If nurses don't like you they call you every hour on the hour. For aspirin." (We all laughed, and the friend said, "There are little ways that nurses can exert power aren't there?"). My perception was that nursing staff often became quite fond of some well-liked male residents, while more distantly friendly with female residents. The female residents themselves may have established the distance.

Although the hierarchical advantage of physicians may have lessened over the last decade or so, they still strongly influence the level of prestige or lack of prestige on a nursing unit or floor. As discussed later in the chapter in the section "The meanings of technology", nurses who work on levels of care associated with invasive medical technologies accrue for themselves the most prestige and respect among nurses in the hospital. According to some interviewees, physicians communicate that they feel higher

respect for nurses on critical care levels than they do for nurses on other levels. Ranjit, a new nurse in critical care, explains this in terms of similar "knowledge bases" between nurses and physicians in critical care, so that the former are able to communicate to the latter in a language that is more "scientific" and more familiar to them:

ICU is far more sexy than medical. Like doctors. I know doctors who think ward nurses are brain donors and ICU nurses are wonderful. A friend of mine is a doctor, and she's like "Oh the ward nurses I work with are a bunch of brain donors, but ICU nurses are really great". There's a greater understanding [by doctors] of what ICU nurses know. They have a respect for that specialized body of information. Medicine is very much a scientific way of thinking. And if you don't think that way, then it's harder to communicate with the doctors. And the ward nurses, you don't generally think in a scientific way. You think, "Oh I've seen this problem again"; it's more intuition. And you can't explain your rationale for why you do things, so doctors discount it. It's a different kind of language.

Kathy, who works in the ICU of a large teaching hospital, said:

One thing I noticed is that nurses that were on the wards, you know, acute care, they were not treated as well by the physicians, they weren't as respected.

#### Front-Line Nurses and Managers

While the hierarchical difference between physicians and nurses has been well studied, the hierarchies within nursing itself have been less well studied. Visible class differences that nurses perceive most readily are those between nursing unit managers and front-line nurses. Hospitals, with their mostly female nursing workforces, appear to have provided new opportunities for some nurses to assume management roles not previously available before restructuring began.

I observed a nurse docilely following a manager into her office on an extended care floor. Another nurse on that floor said to me "I hate being called into her office". In Chapter 8, a front-line nurse describes how distressing it was for her to be called into the manager's and the clinician's offices, in full view of the other staff. I thought of these events as a "humiliation rite" wherein the manager affirms and reinforces her authority

over the front-line nurse, while at the same time reinforcing in front of the other members of the nursing work group, the superior/inferior nature of the relationship and their respective positions in the hospital hierarchy.

Numerous interviewees in this study described interactions with managers in which the manager was clearly maintaining or strengthening her hierarchical position. Some tactics described by nurses interviewed included having "spies" on the floor, "playing favorites", and "squeezing out" front-line nurses seen as potential threats. "Squeezing out" was described by one interviewee, who said that a "subunit" on her floor was created to which the manager assigned the unwanted nurse, and then reduced the hours in that unit, so that the nurse was forced to leave. "Pets" on the floor were rewarded by having requests for prime vacation days, days off, and educational leaves granted, while other nurses found their requests denied. A favoured nurse was likely to be assigned often to the status of "charge nurse" for the shift, an affirmation in the eyes of members of the working group of that nurse's competence. Such a nurse may be exempt from criticisms levelled by the manager at other nurses, illustrated by what Elaine, a nurse in acute care, said:

Our manager seems to pick who she picks on. She picks on the same people all the time; and we say "Why doesn't she point out the things [that other nurses do] that are so obvious, like does she completely miss them?"

The manager is doubtless fortifying her hierarchical position by rewarding favourite nurses, and perhaps also by avoiding confrontation with nurses who may be influential among members of the working group. I witnessed, however, occasions wherein a manager took an influential nurse aside just outside the nursing station to talk to her about a mistake. The manager's knowledge of wrong-doing by staff members - and the

knowledge by staff that she has such information – strengthens her position, since she could potentially censure, give a poor performance appraisal, or a bad letter of recommendation about any nurse who challenged her, based on her reports.

There are, however, limits to the authority of the position of front-line manager. One restriction, a manager said, is limited funding: “I am given a certain amount of money to run the unit”. Another manager said that while she has more autonomy and decision-making opportunities than the front-line nurse, she must operate “within the structure of labour organization” and “follow the rules, legal rules, hospital policy”. She described an instance of role reversal between manager and front-line nurses during a job action initiated by the union, which she did not take lightly:

There is a sort of ripple effect that lasts for a while... I had all my management work, plus non-nursing duties that nurses refused to do..It was important to me their saying “we feel bad you have to do this – it’s not against you”. That is support....I didn’t say a word because I know it’s beyond my control. It didn’t have anything to do with me, it was the labour environment.

The job of manager, C. said, “is a lonely one, and it is difficult most of the time”, because “you are supported neither by your staff nor the administration”. She added that she is considering a different type of work due to the difficulties brought on by ongoing change:

I still do think that I enjoy this job, but for the first time, I feel that I might do something different. So working life is, I found lately, very stressful. I don’t think I have been able lately to do the same kind of job as I had... I feel burnt out, because there are so many changes happening at the same time, and also global change.

During the interview C. looked tired, sighed occasionally, with her head drooping at times. The minute we exited from her office, however, she looked around quickly to see who might be observing her, and assumed a brisk upright manner. She was, according to the interactionist/constructionist perspective, reassuming the official management-

self for presentation at the workplace.

Hierarchical positions can sometimes be undermined from below. For a manager to retain her position, she must gain and keep the support of the dominant clique on the floor. An interviewee related the case of a manager in ECU who was given "a hard time" by nurses on one floor, so that she had to move her office to another floor. This interviewee said that a manager on another ECU floor tried to get the RN's to do "hands on" patient care (that is, activities like washing, dressing, and transferring from bed to wheelchair) but the nurses refused, and made complaints about her (on other bases) to higher administration, thus undermining her position. From the perspectives of the nurses involved, they were maintaining control over their working conditions: "hands on" work such as the PCA's do, is physically much more demanding and often injurious, than is the work of giving out pills and changing dressings on wounds. From another perspective they could be seen to have maintained their privilege (not enjoyed by PCA's nor RN's on other extended care floors) of doing lighter work.

Sometimes ambiguities in hierarchy arise with the deletion of some positions and the creation of others: for example, when the position of head nurse was deleted, so too, the position of assistant head nurse disappeared. The new position of "nurse clinician" appeared to be not well defined.

#### Front-Line Nurses and Other Female Professionals

Front-line nurses on acute and extended care levels enjoy less prestige and respect than do members of other (also mostly female) professions in the hospital, like social work, physiotherapy, occupational therapy, dietician, and pharmacist – even though all such hospital professions require a comparable length of educational

preparation. This is seen, for example, during and after "interdisciplinary rounds".

During the weekly interdisciplinary rounds, representatives of each hospital profession, including and especially the physician, sit around a table in a room to review and update patient records, and formulate plans for the patients. The front-line nurse may be invited to attend these meetings for a few minutes to impart information she may have about specific patients, but on the whole she is excluded from these meetings. The nurse clinician attends throughout the meeting, as does the "home-care liaison" nurse from outside the hospital. In critical care, such rounds typically take place at or near the patient bedside, and the front-line nurse at that level always takes an active part in the rounds.

The de facto exclusion of front-line nurses from interdisciplinary rounds on acute and extended care floors is taken for granted on the basis that she is very busy taking care of patients and therefore has no time for the meetings. If the conceptual work of front-line nurses were seen as crucial, however, no such exclusion would take place. The means would be found to include her in the rounds – for example, by calling on a (reinstated) float pool of nurses to "cover" for the front-line nurses on the day of the interdisciplinary rounds (which last an hour or so). The unspoken justification for their absence from the rounds – that they are too busy – attests not only to the lack of importance given to their conceptual work, but also to the intensification of their work. Moreover, the decrease in conceptual work often causes the front-line nurse to feel ill-at-ease at such meetings, because she is not as articulate as the other health professionals, and therefore she acquiesces silently to what she perceives as their lowered opinion of her input, and retreats as soon as she can to her work on the floor.

(This is evident with “full-scope” LPN’s who are sometimes invited to attend such meetings, who feel even more ill at ease).

From my vantage point in the dining room of an extended care floor one day, and from one wing of an acute care floor on another day, I observed interactions in the nursing station among members of the different hospital professions after interdisciplinary rounds. The sounds coming from the group in the nursing station – clever comments, bursts of modulated laughter – reminded me of an exclusive cocktail party, while around the nursing station front-line nurses carried on their work.

It is notable that of all the professionals in the hospital, only the front-line nurse wears a uniform, as discussed in the previous chapter. The pharmacist may wear a white lab coat over civvies, as does the home-care liaison nurse. The uniform is a marker for service work that is more physically orientated than is the work of the other professions.

Similar to the process of internalization of colonization noted by Fanon (cited in Hedin, 1986; Roberts, 1983; and Thompson, 1987), the diminished level of prestige and respect for front-line nursing is internalized by some nurses. The comments by Ellen, an ICU nurse, illustrate this phenomenon:

So I don’t think you’re getting people that are quite as keen and energetic and things like that, going into nursing. There may be a few, but their role is different, too. They’re not going into nursing to be at the bedside. They will go in to do their time, you know, like three or four years, but they want to get into administration or management, or health marketing or whatever.

The differentiation between front-line nurses and members of the other hospital professions manifests itself in work. The bedpan, for instance, typifies the more menial work of the nurse (this is discussed further under “Stigmatisation of Work” later in this

chapter). The work of front-line nurses is often thought of as parallel to domestic work. Rarely, is this class differentiation of work challenged. One front-line nurse related to me what she considered a hilarious story:

We were really busy that day, and the physiotherapist came up to me and said, "Mrs. X would like a cup of tea". I said to her "Well, you can get her a cup of tea". She said to me "But I'm the physiotherapist!" I said to her "Well, I'm the nurse!"

It is significant that this nurse felt the need to justify her challenge to the status quo by explaining "we were really busy that day". Like the cup of tea and the bedpan, work and artefacts in the hospital are rife with symbolic meanings of class (as well as gender and racialized ethnicity).

### Gender and Hierarchy

Nursing is a female occupation. Usually this gender segregation is conceptualised as "female domination" as in "female-dominated" occupation – referring to preponderance in numbers. This term is likely derived from and meant to be a mirror concept to the term "male dominated" occupations. I find dissonance in the term female dominated occupation, and this dissonance is related to the double meaning of "domination". Some occupations - for example that of Corporate Executive Officer (CEO), and until fairly recently, the occupation of physician – are well categorized as "male dominated". Men have dominated these occupations not only in numbers, but in terms of influence and power over and in comparison to women in those occupations, and over women in other related but subordinate occupations, such as clerical or nursing. The term "male dominated" occupations brings to mind the concept of male dominance versus female subordination. Domination in the sense of power and influence thus has a class ramification as well as a gender-specific one. It also has a



racialized ethnic dimension, in that male dominated occupations like CEO's and (until relatively recently) physicians, are primarily white males.

The term "female dominated" occupation also brings to mind the fact that relations of domination, power and influence do exist within these occupations where women predominate in numbers (Campbell, 1992; England, 1994). The themes of class and racialized ethnicity, as well as gender, permeate these relations. During interviews I frequently heard the phrase "nursing eats its young" which reveals not only the profoundly gender-specific working identity of nursing, but also relations of domination that are strongly exerted within this occupation.

Some nurses, like Violet, believe that domination by some women over other women is due to the inherent nature of women:

It's just the way, the nature, partly it's the nature of women – women behave like that. Women tend to do that when they get in big groups. When there's mixed population of men and women that doesn't occur as much. But when it's all women it tends to happen, I think. When they decide they want to pick on somebody, they do.

Writers on horizontal or lateral violence (Hedin, 1986; Roberts, 1983; Thompson, 1987) attribute the amorphous violence they found among nurses to "oppressed group behaviour" that they liken to behaviour among colonized peoples (using the framework of Frantz Fanon). Thus they implicitly acknowledge oppression over nurses as a group, based on gender, emanating from outside the occupation. They do not, however, identify possible factors such as class domination or racism that may possibly give rise to or exacerbate violence within it. Calliste (1996) and Das Gupta (1994), on the other hand, identify the racialized ethnic dimension but not the class or gender dimension of domination within nursing.

Thus a critical examination of the dissonance brought to mind by the seemingly

simple term "female dominated" occupation reveals yet again the inextricable confluence among the factors of gender, class, and ethnicity. The present study sheds more light on this convergence.

"Nursing leaders" have long been attempting to alter the public perception of nursing as a female profession by insisting that nurses should be referred to in gender-neutral terms, and that more male nurses should be recruited to the profession. Despite their efforts, however, the profession remains a decidedly female one, and almost 97% of its membership in B.C., are women (Fuller, 2002).

Since the nursing workforce is mostly female, most nurses with families have the primary responsibility for caring for children, or for elderly parents, in addition to their work in the hospital. Many nurses with children at home or in a day care use the nursing unit telephone at least once a day to monitor how they are doing, remind them to do their homework or the dishes, and to make sure they are safe. If a child is sick, or has an appointment it is the nurse rather than her husband or partner who stays home<sup>10</sup>. Most nurses, unless they are single, elect to work part-time after the birth of a child until the child is school aged. One manager who had previously been a head nurse stated that one of the reasons she applied for the head nurse position was to avoid shift work when her children were small, "and that was the only option available at that time if you wanted to avoid shift work".

One manager said that she chose nursing because she considered that it was a profession that she could work at part-time, putting career ambitions on hold while her children were young.

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<sup>10</sup> This is consistent with Armstrong (1994), and other writers who refer to women's "double shifts".

The nursing working groups on hospital floors are thus almost entirely female. The few male porters, floor polishers and laboratory personnel appear and disappear on the periphery of these groups, as do the physicians (male and female) and Respiratory Technicians (about 50% of whom are male). Occasionally an electrician, plumber or carpenter (always male) arrives to do some repair work.

General housekeeping staff, though primarily female, is also on the periphery of the nursing group: "good morning's" are exchanged, and the nurses on acute care sometimes know first names. A class dimension is evident in the relations between members of housekeeping and nursing, as noted above in the metaphor of the Victorian household. I heard numerous complaints among nurses on an acute care floor about dust and dirt everywhere, and the poor quality of the work of the housekeepers. On extended care, on the other hand, housekeeping staff is regularly invited to tea times and potlucks, which are organized primarily by Patient Care Aides (PCA's).

Male nurses generally do not emphasise their masculinity: they join in the chitchat on a par with other nurses on the floor, and bring food for fellow staff. I noticed one robust male nurse, however, whose masculine mannerisms such as stretching out arms and legs while sitting in the nursing station and thus taking up more space and encroaching on the space of others, made some nurses feel uncomfortable.

#### Racialized Ethnicity and Hierarchy

Nursing work in Vancouver and the Lower Mainland is not only gender-segregated as a whole, but is visibly segregated further according to racialized ethnicity and this is most clearly seen by comparing the demographics of the nursing working groups on floors corresponding to different levels of care (and levels within acute care).

Statements by interviewees indicated that nurses working on different levels of care enjoy relatively different levels of prestige, privilege, and power. For example, Ellen (a nurse of Anglo origin working in a critical care unit in a large hospital) said that she and her colleagues had been able to successfully oppose a new administrative policy regarding assistant head nurses. By contrast, June (a nurse of East Asian origin) said that nurses on the floor where she worked had more difficulty influencing staffing decisions than did nurses on an adjoining floor:

There's that invisible division...Every time you go in, you never know if you're full staffed. We were scared to ask for extra help if we needed it, we've always just struggled. But the nurses on A ward have no problems. If they feel totally stressed out they have the strength to say "Look, we're stressed out, this is far too big a load for us and we need help". But we have to be stressed out to the max before we can ask for extra help.

The nurses on June's floor were predominantly members of racialized minorities, while the majority of the nurses on the adjoining floor, which was considered more acute, were not.

Ellen, a critical care nurse, gave the following reason for the concentration of Filipino nurses in extended care areas, and their relative absence in critical care areas:

I don't know, sometimes I just think they're just more gentle souls, and they don't want the – fast pace or whatever in ICU. I mean, quite often they're very good, and very caring, you know, but they don't want that big power thing. That's just not in their makeup.

It is notable that Ellen referred to a "big power thing" in relation to critical care.

On the whole, it appears that the range of power, prestige, and privilege (from greater to lesser) corresponds with the levels of patient acuity (from greater to lesser), which examples throughout the study illustrate. Since the levels of acuity are visibly demarcated according to the racialized ethnicity of nurses, it follows that there is also unequal access to prestige, privilege and power according to racialized ethnicity. Unequal access to power and decision-making is also evident when considering the

ethnic origins of managers and administrators, most of whom, in my study, were of white Anglo European origins.

It is possible that “cultural traits” may contribute to maintaining this situation. For example, while nurses of Anglo and European origins may consider their own interactions towards others to be assertive and direct (a desired North American cultural trait), nurses from other origins receiving the interactions may consider them rude and belligerent and avoid such interactions. As Elena, a Filipino nurse said:

there are cultural differences... a Filipino nurse would say ‘maybe you might consider doing it this way’, more subtle, softer, instead of ordering someone to do something – they would consider that bossy.

I observed that interactions among nurses on a very acute care floor are loud in comparison to interactions on sub-acute and extended care floors, which sound softer. (In critical care, where nurses work more individually, the atmosphere is also quieter except during emergencies). May, a young nurse who had immigrated from East Asia while a small child, said that she likes extended care because it is “calmer” and that as a nursing student she did not enjoy “the bustle and activity” of acute care floors. (One wonders if the patients also prefer a calmer environment). The louder sound of interactions on acute care floors, on the other hand, may reflect tensions there due to the nature of work, rather than to “cultural traits”.

Elena said that one of the factors keeping Filipino nurses in extended care is language: “Language is an issue, even though the language of instruction in the Philippines is English starting from the first grade; they are not sure how to express their thoughts sometimes”, she said. Emilia echoed what Elena said about problems with language, when she said: “First of all, probably because of the language - we can

...speak English and understand ...but you see, even our accent is different...We are good workers; we can express more by working”.

Having a Philippine accent set Filipino nurses apart, apparently making communication with nurses of Anglo European origins more difficult. This is similar to the findings of Porter-Tibbett (1992) in her study of “minority” student nurses. I observed some interactions between nurses of Philippine and Anglo European origins. Quite often the latter required the former to repeat what she had to say several times before understanding it. The nurse of Philippine origin also often appeared at the beginning of an interaction not to understand or “take in” what the nurse of Anglo European origin said. Although each nurse in the above interaction was using the same vocabulary and language, it seemed that each was “programmed” to initially hear only voices talking in a certain accent.

During my participant observation, I noticed that Hettie and Elena (both Filipino nurses working in extended care) often appeared to me to be apprehensive. I wondered about the reasons for this, since both nurses had extensive training and responsibility in the Philippines, and therefore I would expect that they would feel confident in an extended care setting. Hettie said, however, that when she started to work in the present facility, she felt like “a lamb being thrown to the wolves”. I asked her what she meant by that, and she said that while in the Philippines other nurses were supportive to the new nurse, here as a new nurse she had been met with hostility. “I think it is natural, that people are territorial,” she explained. Both Hettie and Elena might expect to encounter even more such dominant cultural forms of interaction on an acute care floor.

The thought of undergoing orientation on an acute care floor seems to cause most nurses on extended care floors to think twice before applying for a transfer. Elena said she would not want to undergo an orientation to a new ward, because "I hate orientation, when you feel so stupid, you feel that you don't know anything". Similarly, Lise, a nurse from Quebec said: "I wouldn't want to have to go through that – to fight my way in".

Emilia said that subtle discrimination is a factor in why Filipino nurses are concentrated in extended care:

I don't think the Canadians ..I know they said there are no discrimination, but there is discrimination subtly. ..people are not saying it, but you feel it... you said you are Canadian, but you still feel that you are not Canadian. They don't tend to recognize our potential; they don't give us that opportunity, which I think we have all this potential to advance. But you have to really prove yourself.

Emilia also cited the lack of opportunity for paid educational leave as another factor:

.. and we don't have the opportunity like we do in the States, the opportunity to advance more educationally. Because we are all educated back home. I have a friend in New York, who's an educator - they all have their degrees and everything, because the hospital gave them the opportunity to go to school and learn, and so their progress is more. Whereas for us over here, I don't think we have the opportunity to be reimbursed if we go to school so we can advance more.

Emilia talked about the LCP Program and life circumstances as other factors keeping Filipino nurses in extended care:

Most of the PCA's are nannies first, this is just the easiest way to get out of the country right now, to go through the homecare program, so once they get that they can go to school, or get their PCA for the meantime so they have some money, then they can write the exam and get their registration. So they have to start at the beginning and then slowly progress themselves up. Maybe they are comfortable there [in ECU]. And some of these girls want to earn money, so that they can send some money home. So many Filipinos working as LPN's that are RNs back home and they could not get registered somehow. They cannot pass [even though] they are very smart, and they are very good workers.

Cecilia, a member of the Filipino Nurses Support Group who works in acute care in a

large teaching hospital, said that the LCP is at present the main route for nurses trained in the Philippines to immigrate independently to Canada. While in the 1970's it was relatively easier for these nurses to emigrate to Canada, she said, now they almost never get awarded enough "points" to get accepted as "independent" immigrants. Hettie, also a nurse of Philippine origin, immigrated as a dependent of her husband, not independently. The other nurses of Philippine origin in the study had either immigrated in the 1970's as independents, or they had entered through the LCP Program.

Ranjit a young nurse of South Asian descent who just started working in the ICU of a large hospital, gave a similar explanation:

When my mum immigrated to Canada there was a real demand for nurses, so she pretty much got whatever she wanted. But when other nurses, especially at this time, immigrate from different countries with a nursing diploma or degree or whatever, they have a real uphill battle trying to be a nurse again. They end up doing jobs like being an LPN because their nursing qualifications don't apply. Those barriers are real. And I don't think RNABC and our education system really support having nurses immigrate from different countries. They don't have education programs for them to update them to our levels. And it's a frustration for immigrant RNs to deal with RNABC. If you do get to be a nurse, I mean after dealing with that kind of uphill battle, why would you want to spend another five months going back to school for critical care?

Hettie, a nurse of Philippine origin working in extended care, considers that working in critical care "with all those machines" must take a lot of intelligence. She said that her sister who had "always been very smart" now works in an ICU in the U.S. Thus, the "high tech" reputation of critical care and the mystique about the difficulty of work there, contribute to keeping it inaccessible to many nurses on other levels.

Some Filipino nurses in my study, however, do work in some ICU's, especially in smaller community hospitals. Formerly, some also worked in the ICU's of larger hospitals. Imelda, a retired nurse of Philippine origin who worked in the critical care unit of a hospital that was closed in the early 1990's, said that a cardiologist "set up" the unit



and taught nurses from an acute care ward to read telemetries and closely monitor the conditions of very sick patients. The fact that Imelda and Hettie's sister and colleagues worked in ICU's counteracts the idea that nurses from the Philippines are culturally or temperamentally unsuited to working in critical care levels.

In this section, which is mostly descriptive, the themes of cultural differences, subtle discrimination, language proficiency, and different life circumstances have arisen as explanations for why nurses belonging to racialized ethnic minorities are concentrated in extended and sub acute areas of the nursing workforce. These themes are problematized in the concluding chapter in the section "Factors Maintaining Job Segregation", which is more critically analytical.

#### Stigmatisation of Front-Line Nursing Work

"I'll take a patient - it's not beneath me"  
(Renee, nurse clinician)

The nurse clinician who made the above statement is saying, in effect, that although the work of direct patient care done by front-line nurses is menial, she is willing to do that type of work occasionally to show the front-line nurses that she does not consider herself to be superior to them by dint of her position that is now "above" theirs. "Front-line" care giving implies "hands on" work which is stigmatising – the nurse actually touches the patient while taking blood pressure readings, palpating the pulse, inserting intravenous catheters (IVs), urinary catheters (Foleys), and nasogastric tubes (NG tubes), changing dressings over wounds and surgical sites, treating wounds, administering medications, hanging up enteral feeds (fluid infusing into the stomach) and parenteral bags (nutritive fluid infusing into a large vein) and attaching them to the patient, putting on oxygen masks, washing the patient, turning them from side to side,

helping them walk to the bathroom, and attending to their hour-by-hour needs. While the "hands-on" aspect of nursing work is crucial to the patient's recovery and well-being, it is also the source of lowered prestige for the nurse.

The most stigmatising aspect of "hands on" work is the contact with bodily secretions, epitomized by the "bedpan". The bedpan is commonly the first symbol that springs to mind when hospital nurses are mentioned. It symbolizes "unclean" work. It is quite common for a pharmacist, physiotherapist, resident, staff, or intern doctor, dietician, occupational therapist, social worker, chaplain, laboratory technician who has just come from the bedside of a patient to say very quietly to a nurse "This patient needs a nurse" (or less frequently, "This patient needs a bedpan") after the patient has requested a bedpan. If the patient had been bleeding, was short of breath, or blue in the face, the professional would have hurried out of the room and said (with varying degrees of anxious facial expression) "This patient is bleeding! [short of breath! blue in the face!]" . One reason he or she does not specify the request, or relays the patient's request in a quiet voice is, of course, out of concern for the patient's privacy and potential embarrassment at having their need to void or defecate publicly announced. The bedpan is, however, also a symbol of the different status between the above-mentioned professionals and the front-line nurse (who is also a professional, but of a lesser sort). The nurse is associated with the bedpan, while the other professionals are not. Often, the latter is tactful and does not want to remind the former of her lowly status, nor announce it to whomever is within hearing distance. Sometimes the professional appears embarrassed at relaying the patient's request. If the issue was merely the privacy of the patient, then the professional could have easily slipped a

bedpan under the patient, and then made sure to leave the call-bell within reach.

Patient care aides, who have the most contact with patients, are likely to apply for an activity aide or portering position because it is "clean". RN's speak about some wards, such as day-care surgery, as clean, because patients there almost never have bowel movements, much less diarrhea as they do on the other wards.

While contact with bodily secretions is stigmatising for the floor nurse, it has less effect on the level of prestige than does type of technology and level of decision-making allowed. For instance, the ICU nurse who has highest prestige often looks after patients with continuous diarrhea, such as those with cirrhosis of the liver who must be given lactulose enemas. On the other hand, Extended Care RN's who do not have to clean up incontinent patients (since usually the PCA's do this) has less prestige than the ICU nurse who must do so.

ECU work is further stigmatised by "ageism", since the work is primarily with elderly patients, and it is perceived that a lot of older nurses "on their last legs" work there. "Ageism" in healthcare refers to the stigma associated with aged patients (Butler, 1993; Binstock, 1983; Palmore, 1990; Shenk & Achenbaum, 1993) and often manifests itself in ageist attitudes among healthcare providers (Derby, 1991; Jones, 1993; McDonald & Bridge, 1991; Ryan, Bourhis, & Knaps, 1991; Schmid, 1991).

I attended a staff meeting in one ward, at which someone from higher administration announced new plans for grouping patients according to age on the acute wards. Patients over 70 would be concentrated on "C" Ward, while those under 70 would go to "A" Ward. Within one year, I heard from interviewees that there were a large number of vacancies on "C" ward, to the point that it had to close for a period and then re-open with a smaller number of

beds, and temporarily merge with "A" Ward to get enough staff to cover. "C" Ward was stigmatized when it was associated with aged patients, and thus became a site from which (mainly white) RN's fled. Likewise, extended care is also stigmatized. Not only are the patient/residents aged, but also many of the nurses are older nurses, so that the perception is often that ECU nurses "are not up to speed". June said:

Right away they think that just because you've been in [extended care] for 3 years, you have no common sense, and you're lazy or something. ..there's some nurses that have that attitude and without even really giving me a chance, they've already stigmatized me.

In the present study, I had the opportunity to observe work and interactions between RN's and PCA's in different floors and hospitals. I noticed that in some facilities, RN's in extended care did almost as much personal care of patients as the PCA's did. On wards or facilities where RN's do not do any personal care, or they do just one token resident, there is a rather rigid segregation between RN's and PCA's during work, and socially during coffee and meal breaks. The PCA's bring food to share with each other, and have it around a table. Sometimes one PCA may take a sample of the food to the RN or leave it on her "med cart", to keep friendly relations. Such segregation was noticeably absent at a facility where the RN did the same or almost as much personal care as the PCA's. At this latter facility, both RN's and PCA's shared the same staff lounge during breaks, shared food, and chatted with each other in a friendly manner.

### **The Nursing Labour Process**

According to labour process theory, lower echelon (that is, working class) jobs have taken on certain distinguishing characteristics such as routinization and intensification of work, increased surveillance by others, and decreased levels of planning and conceptualisation. As will be seen in the following discussion of the

characteristics of front-line hospital nursing work, this work is taking on the characteristics of lower echelon jobs identified by theorists.

### Conceptual Work versus Physical Work

"I can identify a problem, and then follow through with it. I want to make sure that today's activity is moving towards the direction of self actualisation" [a nursing manager].

I observed a weekly interdisciplinary meeting on an acute care floor, where professionals had gathered to discuss the progress and plans for patients on the ward. The meeting included the manager, nurse clinician, doctor, physiotherapist, occupational therapist, dietician, social worker, and some students of the latter four disciplines. As the meeting ended and the participants left the room, I saw a front-line nurse by the door putting a large armload of linen from a patient's bed into the laundry hamper. This snapshot image symbolized for me the divide between conceptual and physical work on the ward.

Managers in the present study identified the greater opportunity for conceptualisation on the job as the most satisfying characteristic of their work. Moreover, they correlated the greater opportunity for conceptualisation on the job with greater self-actualisation than was possible when they worked as front-line nurses. One manager said she enjoyed doing a quality assurance project, which allowed "assessment, planning, evaluation". Likewise, another manager said that she enjoyed being able to carry out the complete nursing process, which is to "assess, diagnose, plan, and implement". In other words, compared to the front-line nurse on the floor, managers are in a better position to both conceptualise and execute a plan, and thus she can more fully exercise her capabilities – a point consistent with the perspectives of Marxist labour process theorists like Braverman.

Assessment, planning, implementation and evaluation are officially the four steps of the "nursing process" that students are taught in nursing school. First they assess their patient according to designated schema like the "needs" framework of the U.B.C. School of Nursing (Campbell, 1987) which includes need areas like oxygenation, elimination, nourishment, skin integrity, respect for self from self and others. The nurse then formulates a "nursing plan" to address the needs, to implement the plan to meet the needs, and then evaluate its effectiveness. In the Braverman (1974) framework, this would be analogous to the "conception and execution" of work carried out by artisans. According to the managers interviewed, however, they did not have the opportunity to carry out these steps while caring for patients at the bedside, or at least not to the extent they would have liked. Only after advancing to the position of head nurse or manager could they both plan and execute their work.

Similarly, the nurse clinician who has moved from an educator position to that of a position similar to the former head nurse is also one of the few persons who know the "whole picture". On one acute care ward, this position was created with the backing of most nurses on the ward who wanted "consistency" – at least one nurse who would be up to date with the patients' medical status and plans for discharge, for which front-line nurses did not have sufficient time. On another acute care floor, nurses could be heard to say "Ask Sherry [the patient services coordinator – formerly known as nurse clinician]" or "Tell Sherry" frequently during the day. This was observed on an ECU floor as well, where it appeared to me that telling or asking the nurse clinician about patient-care issues had all but supplanted the function of the report sheet from one nurse to another between shifts. In other words, it is no longer required or expected that front-

line nurses be thoroughly familiar with the patients' history, present condition, or plans for the future. The nurse clinician has become expert in this conceptualising work, while the front-line nurse executes the many tasks related to the overall plan. Some front-line nurses nevertheless attempt to become cognizant of the plan for the patient, while others acquiesce quietly to the trend towards merely carrying out tasks. This trend is intensified with the introduction of LPN's to "full scope" of practice, where they can replace RN's on some wards, but are not expected to know, for example, all the side effects of medications. On such wards, spaces for blood pressure and heart rate to be recorded are written in red pen on the patient's "medication administration" sheet beside cardiac medications (in addition to being recorded on the vital sign sheet). This has become an accepted routine, whereas in the past the front-line nurse decided whether or not it is warranted to take the patient's blood pressure before administering specific medications, without a written reminder to do so.

Conceptual work differs from one level of care to another. As Kathy said of work in critical care - "you have to understand why you're doing what you're doing". This was not as true, she thought, at the acute care level.

### Control and Lack of Control

Control or lack of control over conditions of work and the workplace environment is very important to nurses. Vera, a nurse who had experienced restructuring said this:

I think the fact of having gone through those two transitions, the one not having a choice and not knowing was the hardest – the no control. Whereas the situation where I controlled my own destiny by choosing where I would go made it a much easier transition.

It has been suggested earlier in this chapter that critical care nurses have more control over decisions affecting their working conditions than do nurses on other levels, and

that nurses in more highly acute floors have more say (or conversely, suffer less loss of control) over working conditions compared to less acute floors. This is borne out by interviewees' comments concerning other aspects of the issue of control.

One aspect of control that was important to nurses was the authority to allow or restrict the numbers of patients' visitors and length of visiting time. As Renee said:

You have a lot of control in the ICU as a nurse, especially to do with the family - whether or not you want the family to visit. Most ICU's you have to ask to come in. There's some form of a gate, whether it be a phone, or a physical gate or a door. Some nurses choose to stick to the rule of 5 minutes, 2 people. And that's their comfort level with families.

The authority of critical care nurses to control visits, and the lack of free entry to the units by visitors contrasts markedly with the lack of authority in this respect for nurses in acute care wards, and extended care wards. In the narrative of Dora, described in "Ethical dilemmas" in Chapter 6 one of her complaints was that "these people could just wander in any time of the day or night". She thought if visiting hours were set and enforced it would make working life at least a little better:

This is what upsets me, is that I feel that my hands are tied, that I have no say - that nothing will be done, no matter what, until a nurse is really injured, once someone there really gets the shit beaten out of them, or [gets infected with a needle], nothing will be done. At least give me that power back that I can say, "Sorry folks, but visiting hours are over, it's 8:00 we need to get people settled now."

Lack of control over visiting hours seemed to epitomize the feelings of general lack of control and powerlessness this nurse felt.

Other aspects of interaction between nurses and patient families illustrate control versus lack of control. For example, on some extended care floors I observed that family members could control how the nurses delivered care to their family member, whereas on critical care floors this was not the case. On one extended care floor, for example, a family member had hired "paid companions" around the clock to sit with the



patient/resident, and record everything the nurse did. On at least one occasion the companion told the nurse she should give a medication later according to the wishes of the patient's family member. Some nurses appeared fearful or very careful in their dealings with this patient/resident and the family member.

On an acute care floor I observed two family members question nurses daily and at length about blood test results and other matters concerning their family member. As mentioned in the interaction described in Chapter 6 between a nurse, a steward and a manager, some family members complain to the manager of the floor about individual nurses, and on one occasion I heard a patient's family member say to the nurse: "My mother said you were rough when you turned her this morning". On critical care floors, on the other hand, I never saw family members question a nurse in the manner described above, or attempt to exert control over the nursing care.

Another aspect of control is the degree of decision-making allowed in one's job. In terms of medically related decisions, this ranged from a relatively high degree of control at the critical care level, to the lowest level of control at the extended care level. A critical care nurse decides when and how much morphine she will give to a patient with chest pain (within parameters), how much she will adjust an antihypertensive infusion, or ventilator settings according to symptoms. She would not hesitate to phone to ask the resident to order a medication she thinks is needed. An acute care nurse has a list of "prn" medications she can administer according to symptoms and orders, but would not administer anything not ordered without consulting with the doctor; she would describe symptoms and wait for the doctor to order the appropriate medication. An extended care nurse has very little discretion with regard to medications or other

treatment. For instance, enteral feeds – fluid nutrition through a tube to the stomach – are always given through a pump (the “kangaroo” pump), rather than through gravity, and this is not up to the discretion of the nurse. Sometimes these machines continue to “beep” (alarm) with no known cause, which is very distracting and annoying to staff and resident alike. I passed on to my nurse “buddy” during one rotation in fieldwork, that on some floors they let the fluid flow by gravity and do not use the pump if the resident does not have a fluid restriction or malabsorption problem. This nurse did not want to let the fluid flow by gravity, however, even though there was no rationale for not doing so in this case, other than the fact that using the machine was the usual practice on the floor. She feared censure.

Control or lack of control was often described in terms of the level of decision-making allowed on other matters. Dina, in acute care, said that staff on her floor were happier now at least in part because the new manager was “allowing staff to take responsibility for making decisions” about such things as requesting extra staff from the staffing office when needed. I noticed that on three floors – one in critical care, two in acute care – a source of satisfaction for some nurses was having the responsibility for scheduling shifts for the whole ward. In one acute care floor it took the form of “self scheduling”, while in the critical care unit, and on the other acute care floor, individual nurses had volunteered for the task of creating “a new rotation” which had to be voted on by all nurses on the floor.

Some managers were referred to as “controlling” or “a control freak”. Dina mentioned that in the new hospital she went to her first manager used several tactics to control nurses, which included watching the clock to see when they came back from

breaks - although this was considered outside the norm: "And I said to somebody I have never been timed, ever', and I said 'that is just not done'". This same manager also hovered over nurses who were taping their reports near the end of shift, urging them to hurry up "so that she wouldn't have to pay overtime".

She also suggested that the floor could do with less staff, and she refused to believe it when we said that levels of acuity differed among the patients. The staff was too scared to ask for extra help. She was very controlling about how the ward was run, and how staff did things.

As restructuring continued, this manager was replaced by another, and from this interviewee's perspective things got better with respect to feelings of being less controlled:

The manager that we've got now, we don't see much of her at all, actually...of course the unit manager was often off in meetings, constant meetings, it seemed. Sometimes it's a little out of control down there now [slight laugh] but it's a much happier place. The staffing levels haven't increased, they've decreased, [but] I think we're happier because the staff for some reason seem to interact better, there's better interaction with the manager, there's not this feeling of being controlled by... And sometimes there are decisions made that we might not always agree with, like with staffing, and often it's a budgetary thing which we have no control over, and she doesn't even have control over.

In this interaction, the interviewee is saying that seeing less of the manager contributed to feelings of the staff that they were not being controlled, but since the previous manager had also frequently been away at meetings, there was some other factor that she could not put her finger on, that made for a happier floor and "better interaction with the manager". It is noteworthy that the new manager allowed some decision-making by the staff, and shared with them her own feelings of lack of control over issues like staffing and budgets.

Ellen thought that managers who were controlling were intimidated at the thought of sharing power with those further down the hierarchy:

Well, people have different management styles. But pretty consistently, the managers

there have been very good for empowering their staff. They don't have to have all the power, they're very willing to delegate and share it. I guess they're not – well, they're not intimidated.

Controlling prerogatives by some managers over other nurses are exercised through symbolic acts such as calling into one's office, timing coffee breaks, designating and posting charge nurse status, or conversely denying some nurses charge status. I call these acts humiliation rites, though not everyone perceives them as such. For instance Dina was called into her manager's office and taken to task for using a colloquial expression the manager considered to be vulgar. I tried to discern if it caused Dina embarrassment to be called into the manager's office, but her comment when I asked her how she felt being called into the office was "Oh, I knew what it was about", indicating that she took it for granted that a manager has the prerogative to call a nurse into her office. Once in the office, Dina vigorously asserted her right to be respected by citing her record as an excellent nurse and team player, and the manager acceded: "and she just backed right off. So for me, I had no problems after that. She knew that I would come back, I stood up for myself, and I knew, I was quite comfortable in what I was doing".

Dina did not mind being called into the office, as she felt a sense of control in the situation. It is notable that Dina works on a floor that is highly acute. Two other instances of "calling into the office" were described earlier in the chapter as humiliation rites – and these took place on a sub acute floor and on an extended care floor.

The importance of having a sense of control over decisions affecting one's life (including one's working life) is acknowledged by researchers in the health promotion field, and indeed at the governmental level (Province of British Columbia, 1995). In their

discussion of the effects of "construal", the health consequences of perceived efficacy and control is articulated by Ross & Nisbett (1991; p.214): "There is increasing evidence that the effects of control, both actual control and perceived control, may be mediated by physiological factors related to the functioning of the endocrine and immune systems".

### Routinization of Work

The standardization of the local, whether through machine or computer technologies, government regulation, work discipline, or a socialization of consciousness, is the essential local complement to the ubiquity of the organizing text [Smith, 1999; p. 93].

"Flow sheets and "clinical pathway sheets" (See Appendix D) are examples of the "standardization of the local" referred to by Smith (1999). They mean more routinization of treatment and less discretion for the nurse to give her impressions or interpretations when charting the patient's condition. Previously charting was done "head to toe" – the nurse conceptualised subdivisions of the patient and charted her observations and impressions about aspects like level of consciousness, the respiratory system, and cardiac system; or she followed a schema like the UBC Model for Nursing (M.A. Campbell, 1987). Now, however, she is more likely to be ticking off boxes on a flow sheet, which represents the conceptual work done by another nurse (usually a "clinical nurse specialist").

Routinization in thinking during nursing work is often described as the attribute of being "task oriented", noted by Shauna, when she said, "They're so much into the task, that they forget this is nursing - they're so task oriented. Tasks, that's it. They forget there's people around". Jane said she was "raked over the coals" for "doing her own thing" on an ECU floor. She said:

Well, one of the things I like to do with the tube feeds, is to flush with warm water. I think of it as a comfort measure. They always have cold fluid pushed into them, and then flushes with cold water before and after – it's such a miserable life, I think that they get a little comfort with the hot water.

(Jane's experience is also cited later in Chapter 6, in a discussion of the ethical dilemma of tube feeds). Her initiative, however, was not rewarded. Jane was called into the manager's office, and was subsequently "followed" for two days by a nurse clinician to assess her practice. Flushing a resident's feeding tube with warm water, rather than with normal saline, was contrary to the suggestion by the dietician, which had been written onto the medication sheet. Jane argued that it had not been a doctor's order, and that there really was not a good reason to use normal saline, since the resident's hyponatremia [low sodium blood level] was marginal and chronic. She also argued that the resident in question had been moved from a "level three" to a "level two" intervention status, so that comfort should take priority over the medical intervention of addressing the hyponatremia. The manager, however, was adamant that Jane should have followed what was written on the MAR:

She said that she was concerned I was not reading the MAR properly, and had therefore missed that I should have flushed with normal saline and not water, and if I made a mistake like that, I could easily make a mistake giving a wrong medication next time, which could have legal implications. She said that I can't "do my own thing" like that; I had to consult with other members of the team first.

It is interesting to note that during the end of my fieldwork, the administration of one hospital was starting to introduce LPN's onto a palliative care floor, and onto an extended care floor. These LPN's were being taught to do some things formerly done only by RN's, such as changing dressings, taking blood sugar readings, and even giving medications. Reskin and Roos (1990) noted that routinization of professional work precedes its takeover by less professional members of the occupation. That pattern is

being replicated on hospital floors. It became very necessary to hospital administrators that nurses in ECU and sub acute areas follow the rules exactly, in order that their work could be easily replicated by less qualified staff.

The acute care floor can be seen as in a sort of limbo between critical care, and sub-acute care (such as palliative care, for example). Nurses do not and are not expected to make medical decisions of any kind in acute care, unlike in critical care where nurses are expected to be able to make snap decisions in emergency situations. In palliative care, nurses often discuss and think of solutions to problems, and this is expected of them. In extended care and acute care, on the other hand, nurses tend to be rule-based in their thinking, rather than thinking of solutions to problems independently. In acute care, this causes unease, since rule-based actions - not always well understood or completely memorized - are potentially applied in life or death situations.

In the matter of the "code that was not a code" discussed in Chapter 6, the nurse and/or the charge nurse could have gotten some Narcan from the medication room, and administered it to the patient themselves. In censoring the nurse in the "code that was not a code", however, the manager did not fault her with failing to make a decision to use Narcan; rather, she faulted her for asking to have a code called when it was marked in the Kardex that the patient was a "no code", and for leaving the patient's bedside to call the code – criticisms that appear to be rule-based. Benner et al. (1996) consider rule-based thinking as characteristic of the novice level of learning. They conducted their study, however, in a critical care setting in the U.S. In Vancouver and the Lower Mainland, nurses new to critical care have usually been recruited from acute

care floors, where that kind of thinking is more rewarded. It is not known by this researcher if that is the case in the settings where Benner and her colleagues did their research.

As Leidner (1993) notes in her study of interactive work in service work, management must recognize that work cannot be fully routinized. There must be room for "ethnological competence" – the capacity to interpret and make judgments on the bases of this interpretation on the part of the health care workers like nurses. This should be elicited from nurses and supported whenever possible by levels of management and by other health professionals. Not only is this desirable for purposes of providing better overall care to patients, but also for purposes of improving the lot of nurses – enabling them to exercise their "purposive will. [so that work] is something which gives scope to bodily and mental powers" (Marx, 1972 [1867]; p.170 ) rather than something requiring only close attention to the details of the task.

As discussed above, routine can lend a sense of security and stability and sense of safety on one hand, but on the other hand can prevent feelings of self actualization, if it takes the place of or circumvents decision-making. Routine is very prevalent on ECU, but less prevalent on acute care. In ICU, routine is also very strict for life-saving situations, which also gives a sense of security, but it is more flexible with things that are relatively minor, illustrated by the comment of ICU nurses - "don't sweat the small stuff". Routinization in acute care is seen as "more paper work". Ticking off boxes on flow sheets circumvents "useless" charting such as subjective and non-informative comments like "the patient had a good day". At the same time, however, it prevents or discourages more articulate writers from communicating their subjective impressions.



Narrative and subjective impressions and observations often give the reader valuable clues and real information about what is happening to the patient that may be missed on standardized forms.

### Intensification of Work

"I think it's busy because people are getting sicker and sicker in the hospital all the time. And the hospital is under a lot of pressure, so a lot of people who 5 years ago would have spent an extra few days in intensive care, come down to us when they're pretty unstable still"[Elaine].

Nurses have been experiencing the intensification of work on some acute care floors due to the higher average acuity of patients they must care for. As Elaine pointed out above, patients are transferred from critical care floors while still not medically stable, in the estimation of acute care nurses. Also, patients are discharged from the hospital earlier than in previous times. Thus nurses tend to work more with patients during the initial acute phase of their illness or post surgery, but not during the beginning convalescence phase, which used to be a more relaxed less demanding time in terms of nursing work.

Some nurses find that work has become unpleasant due to its intensification. As Dora said, "It's very seldom we go to work and have what I would consider a decent day. Like work at a normal pace. It's always running and a lot of things happening – a lot of sick people and that". Louise said, "Full time people are so drained, so many demands and so many days one after the other is a killer".

Some nurses, on the other hand, enjoy the stress of working with sicker patients, and it is one of the reasons they choose to work in acute care or critical care. Kathy, an ICU nurse, said:

Your patient can suddenly take a nosedive and start plummeting and you have to be ready, sometimes you are literally keeping that person alive, you just have to be right on top of it, you can't stop focusing for a minute. It's emotionally, it's mentally stressful...

love that kind of stress. I like being able to be involved in that. And I think that's the reason I left floor nursing, is because I like to be able to be that involved.

Elaine said with pride about the acute care floor she works on: "We have the sickest patients in the hospital [that is, of all the acute care floors]", and she likes the fast pace of work because then: "I feel like I'm really using my brain when I'm working fast".

The stress of working with very sick patients in acute care, however, is not as enjoyable as it is in critical care, because the nurses in acute care do not have the resources to do such work with confidence. "Their workloads are heavier, and if one patient crashes then they're tied up with that patient and then they have no resources to help them out", said Kathy. Other nurses are so busy that "they don't have time to help you". Elaine was looking forward to transferring to critical care, where, she said:

I think there's a lot of support in critical care. The X-ray's nearby; CT scan is nearby; the respiratory therapist is nearby. The doctors are nearby if my patient starts to code or goes downhill. I'm going to have support. My colleagues are there; my patients are going to be closely monitored.

The intensification of work, then, is apparently most acutely felt on the acute care floors, where nurses care for patients with higher acuity, but without the material and psychological support that is available in critical care to care for very sick patients.

The intensification of nursing work differs from intensification of work in other sectors, for instance in sawmills, where management policy directs fewer people to do more work while aiming for higher productive output. As Reskin and Roos (1990) note, such intensification of work is often the prelude to automation in the industry.

There are, however, parallels with nursing work. Health authorities are saving money by transferring patients from critical care to acute care earlier, and discharging patients out of the hospital earlier. In extended care and sub-acute care floors, RN's are

being replaced by lower paid LPN's. Acute care is in a fluctuating state in terms of patient acuity, with a limited number of RN's coping with the fluctuation and unpredictability, while the health authorities work out policies of cost containment and restructuring.

### The Meanings of Technology

"Modern Western sciences and their technologies have always been regarded with both enthusiasm and dread" (Harding, 1991; p.2).

The following is an excerpt from my diary written after visiting the Intensive Care Unit (ICU) of a large teaching hospital. This visit followed relatively long periods of participative observation that I had recently spent in acute care and extended care floors. It had been a few years since I had seen the inside of an ICU, and I now saw this one with new eyes. I recorded my subjective impressions upon first entering this site, and am including the following excerpt in an attempt to convey the "other worldliness" of the ICU - its capacity to frighten and intimidate not only visitors, but nurses and staff from other floors who occasionally visit it:

The patients with eyes closed as though in suspended animation, appear somehow elevated on their beds in the little glass cubicles, with the row of nurses in chairs before them like priestesses administering to human sacrifices on raised platforms. The sounds of equipment – the rhythmic sigh of the ventilators, the regular beep beep of heart monitors, muted alarms, the hiss of oxygen, the moist rattling of phlegm being suctioned from endotracheal tubes – is complemented by the sights of high tech: above the level of the bed and surrounding it are numerous translucent large and small bags of fluid hanging from movable metal rods suspended from the ceiling like fat icicles, connected by tubing to machines which dispense the liquid into the patient's jugular and peripheral veins with lights winking; poised above the head of each bed is a large greenish hue TV screen showing rows of white lines with peaks and valleys – the screen alarms and spews out strips of paper now and then; large corrugated tubes attach the breathing machine by the side of the bed to the endotracheal tube in the patient's nose or mouth.

The above excerpt from my diary illustrates the different atmosphere of the critical care working space compared to that of the other two levels of care, and illustrates the physical and psychological dominance of "high tech" at this level of care, both on the

nurse and patient. Perhaps it makes understandable the reverence, awe, and even fear and intimidation about critical care expressed by some nurses working in other (non-critical) areas of the hospital. Critical care and its technology have the reputation of crisis, life and death decisions, with the possibility of sudden death always present.

As the report *Understanding Canada's Health care costs*" (Provincial Ministers of Health, 2000) points out, expenditures on high technology, along with expenses in pharmaceuticals, are rising at a very fast rate, and taking up ever-greater proportions of the money spent on health care. This was also pointed out in the *Closer to Home* report of BC government in 1991 (Province of British Columbia), in which the authors attributed some of the hospital demand for high technology (such as Magnetic Resonance Imaging machines – MRI's) as an attempt by hospital boards to compete with, or gain as much or more prestige than other hospitals. Hospital boards associate the purchase and use of high technology items with prestige for their hospitals (Province of B.C., 1991). Similarly, the use of high technology items on hospital floors bestows prestige on nurses working on those floors. The term "high technology" is applied to instruments and machines used by physicians doing complicated medical procedures, and is associated with high prestige. The use of other technologies in the hospital which are equally complicated, such as the pneumatic lift used on extended and acute care floors, or computers that are used throughout the hospital by the unit clerk and nurse, does not accrue prestige. The use of high technology by nurses does not, however, necessarily involve higher levels of skill (which is consistent with Braverman, but not Buroway).

The Swan Gantz catheter ("a Swan") in the critical care unit is an example of a

prestigious technology that is considered to require superior skill. This triple lumen catheter is passed through a trocanter into the patient's jugular vein by the physician until it reaches the heart; a balloon on the tip is then inflated, and is carried by the stream of blood through the heart and towards the lungs, where it is deflated. Nurses "set up" the paraphernalia and attend while the physician inserts the catheter. They can then perform the "delegated" task of doing cardiac outputs at intervals during the day, which involves injecting ice-cold water into one port of the catheter and recording the temperature of the blood as it passes by another catheter port. These values are entered into a computer, and the cardiac output can then be deduced. While this task is prestigious, the principle of the technology itself is not more complicated than that of other technologies used in other parts of the hospital.

The technology of a pneumatic lift, for example, requires as much or more skill than does that of measuring cardiac outputs. The operators of the lift (RN's, LPN's or PCA's) place the patient on a sling, attach the sling to metal arms of the machine, press a button to raise the patient and sling in the air, then manoeuvre the patient and machine so that the patient is positioned above his/her bed, then lower patient and sling to the bed surface. Placing the patient on the sling in the first step requires exactness so that the head will not either flop backward, or too much forward, and while using the machine to raise the patient, the operators must watch carefully that the patient is balanced, and will not slip out of the sling altogether. Despite the skill required for this operation (indeed, many nurses in acute and critical care levels do not feel confident to use the pneumatic lift) it does not accrue prestige for the nurse or care aide using it. Likewise the operation of an electric wheelchair used in ECU's is not prestigious.

Inserting IVs – done only on acute and critical care floors -is more prestigious than using a pneumatic lift. Insertion of IV's, a simple technology compared to pneumatic lifts and electric wheelchairs, used to be done by physicians, and then became a physician-delegated task. It is now done primarily by nurses, and a nurse who is good at it gains recognition and respect. Likewise, taking out central venous catheters (CVC's) – also a simple procedure - is now a physician-delegated task. During my fieldwork on a relatively prestigious medical floor where patients had telemetries and central venous catheters, I heard the manager say to the nursing staff "this is a high-functioning floor", thus fortifying its prestige to the nurses working there. The term "high functioning" is usually applied to a patient suffering from a debilitating type of condition or disease, but who is functioning in society almost normally: for example, the description of a quadriplegic patient as a "high functioning quad" or a schizophrenic patient as "a high functioning schizophrenic". The term "high functioning floor" appears to be associated with the fact that it is associated with "high technology" which is very prestigious for the hospital floor and for the hospital as a whole (Province of B.C., 1991).

This study partly supports a labour process analysis linking advances in technology at the workplace with greater routinization and less control over the labour process, but it is not fully supported. As Campbell (1992) noted and the present study confirms, computerization in hospitals has been accompanied by the introduction of standardized forms to be filled out by nurses doing their assessments of patients. In place of the nurse's more subjective interpretations of the patient's condition, and her writing of this in the chart, she must now tick off boxes in standardized forms. Even standardized doctors' order sheets are now available. This routinization of medical and

nursing assessments, Campbell (1992) says, is the prelude to ever more computerized accumulation of data, which in turn lends itself well to future billing per assessment or procedure. One could say, then, that the routinization of work has slightly preceded and facilitated the increased technological advances in hospital work.

In studies of occupations that have become feminised, a similar phenomenon has been found: Reskin and Roos, for example, found that the entry of women into pharmacist and baker jobs (Reskin & Roos, 1990) was accompanied by the routinization of the work, the flight of men from the occupations, and was followed by increased automation of the jobs. Decreased opportunity for decision-making on the job in nursing work, however, is not necessarily correlated with an increase and complexity of the technology used. Nurses in the ICU's have greater opportunity for making what were formerly medical decisions, than do nurses elsewhere. In terms of planning their nursing work, however, the degree of decision-making does not appear to vary much from one level of care to another. Nursing assessment in the ICU also involved ticking off flow sheets, and recording vital signs (more vital signs than on most floors). Although the interpretive work in assessment is still present, as will be seen later in the study, this conceptual work is being less and less recorded on most floors and units. The greater degree of medical decision-making by ICU nurses is correlated with the presence of more complex medical technologies such as heart monitors. Thus with the introduction of complex technology there, nurses have gained opportunities for decision-making, while doctors have relinquished some aspects of their work. It was noted that the pneumatic lift used on extended care floors (and to a lesser extent on acute care floors) is also a complicated technology, but is not correlated with either

more or less decision-making by nurses. In extended care, usually PCA's use the pneumatic lift; when and on which patient/resident they use this technology was at the discretion of the physiotherapist.

Illustrating the symbolic aspect of hospital technology, prestige of work— an ascriptive attribute — varies, not according to the skill needed to operate the technology or its complexity, but according to who else uses it, and how closely it is associated with medical diagnoses and treatment. The use of technology is very likely also gender-related. Nurses are taking on more “physician-delegated tasks” which used to be performed by (primarily male) physicians (a phenomenon called occupational “poaching” by Abbott, 1988). At the same time that the medical profession is relinquishing some of its procedures, the profession itself is “feminising” (that is, beginning to be occupied by larger numbers of women), with a smaller mostly male fraction of its membership enjoying very high salaries and prestige. Procedures relinquished to nursing no longer command respect and awe for the medical profession, but for nursing at the moment, they do. For the elite in medicine, respect and prestige accrues now from newer and higher “high tech” procedures, performed primarily by male physicians. These include procedures such as surgery on unborn fetuses, probing the brain to alleviate symptoms of Parkinson's disease, angioplasties, and others.

Tomaskovic-Devey (1993) likewise found that prestige of jobs varied according to who performed them — for instance jobs performed by women and minorities had lower prestige by dint of who occupied them. Thus prestige of technology is impacted by the intersections of race, class, and gender.

As Buroway (1979) noted in his ethnography, technology is associated with



hierarchy. Contrary to his findings, however, the levels of skill associated with different types of technology do not necessarily correlate with higher or lower levels of prestige or level in the hierarchy.

Like other artefacts in a hospital, technology is not a neutral phenomenon, but is highly symbolic. The value of a technology is very subjective, subject to the interpretation of the persons using it, and the interpretation of the witnesses to its use. The meaning of technology is intertwined with the complex interactions and their meanings within and between hospital work groups.

### The Quest for Self-Fulfilment

The quest for self-fulfilment was a prominent theme in interviews with managers and front-line nurses. One former head nurse said she left her position as general duty nurse on the floor because "I knew I could do better than that". For those who wanted a greater challenge than general duty nursing, then, or to move up in the hospital hierarchy, the position of head nurse was an obvious and achievable goal. (A very small number of those with ambition could conceivably, if they acquired a degree, become a Director of Nursing - DON - for the whole hospital.).

As noted in the previous discussion of conceptual work, managers stated that they liked the conceptual part of their work, and correlated this kind of work with more self-fulfilment or actualisation than they could achieve as a front-line nurse on the floor. They also gained more self-actualisation through seeking greater challenge, and by moving up the hierarchy.

Manager C. chose to enter nursing because she thought it had possibilities of becoming a career. She knew that "I couldn't be vice-president right away", so she

started with the job of night shift supervisor at a community hospital, which she found very stressful - she couldn't sleep and had two car accidents. She said of that time: "honestly I did everything I could possibly do because I knew I needed to succeed in that job, if I wanted to climb up the ladder so called". She also persevered because she did not want the "embarrassment of failure". In the quest for self-fulfilment, she was ready to make sacrifices.

Most front-line nurses who do not aspire to climb the hierarchy attempt to find fulfillment or challenge in their work on the floor, or by transferring to a different level of care. As Ellen said:

usually people that go into, say like Emerg or ICU are very progressive, they're a different personality, they want to challenge themselves. Most people who go to ICU have done something like that [med/surg] for a while and then just progressed beyond it. They thought "I've got a handle on this and I'm not being challenged anymore, so I want to go further".

Some nurses achieve satisfaction through working hard. Nurses judged to be conscientious hard workers are respected among their peers, which brings to mind the "making out" described by Buroway (1979) and his question "what makes them work so hard?" Nurses who work too hard, though, generate unease: for instance Mona was constantly stocking up the minicarts outside patient rooms before anyone else got a chance, or tidied up the med room and nursing station, so that nurses sitting in the station chatting felt guilty.

Some nurses take pride in working extremely hard, apparently as a substitute for other forms of self fulfillment, as illustrated by this quotation from Shinder:

And I think because people there are quite overworked and I don't think management realizes how overworked they are. They've been that way for so long that they're quite bitter about it. So, the only pride they have is that they can take care of 16 patients. It doesn't matter how poorly they take care of 16 patients, they can do it.

Other nurses find fulfillment through pursuits outside the hospital, described by Ranjit:

The people I work with in ICU are all very confident, knowledgeable people, and they're all – they do other things besides nursing, like they do more than just nursing and family. Everyone's a marathon runner, or working on their masters or something like that.

Some nurses do not consider self-fulfillment through work to be a priority, but have other priorities, such as employment security, assured pension, and steady income.

In this chapter, the issue of class has been discussed within two frameworks: that of hierarchy and that of labour process theory. The conception of hierarchy is derived from stratification theories, which in turn, draw upon symbolic interactionism: relative locations in the hospital workforce are meaningful only through sets of specific interactions that establish and maintain them. The discussion of the nursing labour process, on the other hand, draws closer to a Marxist definition of classes. Both frameworks help to illuminate aspects of front-line nursing work, such as self-esteem and the degree of control over one's work, that are important to understand in the later discussion of the interactive environment of nurses. In the following chapter, themes arising from narratives of restructuring and new ethical dilemmas further illustrate why nurses are feeling distress. This ties in with and sets the stage for Part Three of the study, where the problematics of interaction are examined and analyzed.

## CHAPTER SIX

### **DISTRESS: NARRATIVES OF RESTRUCTURING AND ETHICAL DILEMMAS**

The two themes described in this chapter - narratives of restructuring and ethical dilemmas - illustrate aspects of work that cause distress and anxiety among many nurses. This distress and anxiety, as will be shown, help to create the conditions for dysfunctional patterns of interaction such as targeting. Restructuring meant that hospitals closed or amalgamated, and head nurses were replaced by managers. Instead of head nurses who were familiar with front-line nurses and their work, a succession of more distant managers took their places. The changeover was often less than friendly to all concerned. No one knew from where decisions emanated, and most people felt marginalized from decisions and events.

A generalized feeling of loss of control prevailed, as well as uncertainty and fear about the future. Nurses were preoccupied by these changes, and often unable to give needed reassurance to newly transferred or recruited nurses to their floors, who felt unwelcome and unprepared. New and distressing ethical dilemmas intensified during restructuring, such as ambiguity about which patients should receive aggressive treatment in life-threatening situations like respiratory arrest. As will be seen in the section "The code that was not a code", this ambiguity sometimes contributed to some nurses being evaluated as not competent by their peers. The chapter begins with narratives of restructuring.

## Narratives of Restructuring

### A Succession of Managers

Dina talked about her manager, and about the succession of managers on the acute care floor where she works:

Because at that time there was big talk about the hospital closing, so everybody was watching their back. ...I think when budgets were coming down, there was slashing, financing the hospitals, and that. So she was worried. There were a lot of people really worried about their positions...There were two different managers and they deleted a position, which I thought was very poorly handled. Obviously only one of the two managers got to get the job. The manager of this floor ended up having the position - the other one, actually I think she had decided she wasn't going to fight it. It was very unpleasant....Then the manager from here became the manager of [another] floor also. Now she has since left, and we have a manager for our floor, but then again, she's working out of [another hospital] as well. She has responsibilities there, plus, our floor and day care and upstairs. Their responsibilities have increased substantially. They brought one manager from [a large hospital], who handles - I'm not too sure. So there's been lots of changes and that's very difficult for staff, too.

Iris described a situation of "revolt" on an extended care floor when a well-liked manager

was replaced by a new one:

When I first started working here, each side had head nurses. There were 6 head nurses in the building. Now, there are two managers...the side that got Priscilla [as a manager] was in revolt, and never settled down. When floats came to our floor [before the new manager] they used to say everybody loves to come to our floor, it is a peasant unit. ..everybody got along, there was not racial division, there was no division between the RN's and the PCA's who are the bulk of the workforce. We had social events that we all went to, we were friends amongst each other, there were no outcasts. Almost instantly there was a division, there was a divide and conquer situation happening. There was a group of RNs were picked as favourites...it all started to go downhill.

Jessie, a former head nurse from a hospital that had closed, said that she noticed things were changing in 1986, when head nurses had to start doing budgets for the ward, which had formerly been done by the finance department. "I detested doing budgets", she said. She thought the department of nursing had something to do with the decision to have head nurses do budgets, but was not sure where the decision originated. Head nurses previously had been responsible for the day-to-day running of

a single nursing floor, and were familiar with each nurse and each patient on the floor. Some had been known as "real dragons" but most were usually thought of as dedicated to proper patient care, and to their staff, and above all, as fair. A few, such as Jessie, were well known throughout the hospital as "standing behind their nurses" – that is, to take the nurse's side in a dispute with, for example, a physician.

In 1991 the higher management announced that head nurses would become, or would be replaced by "nursing unit managers" (referred to as "NUMS") and that incumbent head nurses could voluntarily make the change, or eventually they would have to leave. "Only two volunteered right away to do it" said Jessie, "and those who agreed to it were given nurse clinicians, whereas I, who did not agree was not given a nurse clinician".

Jean, another former head nurse, was offered limited options after the extended care annex in her hospital was closed, so she took a position as head nurse at another hospital. Soon after she arrived, the title of the position was changed to nursing unit manager, and she was no longer a member of the union. She says there was little choice in this matter:

Either you came out of the union, or else you go back into general duty nursing. The DON gave mention of it before the memo came out that there was going to be some kind of transition, involving coming out of contract and if you don't, the position won't be yours.

She stated that she didn't foresee any problems with this, and since she liked her job, she went along with it. "At the time management wasn't going through the changes so drastically and everything else that's happening now". She thought that if all else failed it wouldn't bother her to go back to being a general duty nurse, because "I like dealing with people more than anything else". At that time, she said, the only difference was in

the title of the position, although she did notice a large increase in the numbers of time-consuming meetings she was required to attend. She did not enjoy the meetings, where participants "rehashed the same things and go over the same policies about 50 hundred times". According to Jean, she developed high blood pressure while at the new hospital, for which she is presently under medication.

Jean felt a sense of betrayal by her immediate superior in the upper management with respect to how she was told about her termination. This individual smiled and acted friendly and gave no hint of the impending termination, which took place two weeks later. Indeed, Jean learned about it from another front-line manager before she learned about it officially from this immediate superior. She considers that the new type of management is sneaky, political, and "one doesn't know what is going to happen next". She now works in another setting and is happy with that, for "I don't need to prove myself anymore to anyone".

#### Loss of Control

Nurses who had been transferred from a hospital that had closed, appeared to have gone through emotional and physical stress and illness, which was evident even seven years after the event. Vera, who had been an Operating Room (OR) nurse in the previous hospital, was said by another nurse friend to be "still in mourning" from the changeover. Vera said that soon after beginning work in the OR of the second hospital, she developed severe skin rashes and respiratory problems. After working there for two years she had to take an extended sick leave. "They would measure my lung capacity with a peak flow meter. At the beginning it would be 450; by coffee time it would be 200", she said. After seeing many doctors, she found one that identified her problem as

latex allergy. Although latex gloves had also been used in the OR of the previous hospital, it appeared that the allergy had been triggered only after the move to the OR of the second hospital.

Doreen had been one of the nurses working in an acute care floor of a hospital where I did participant observation, and she had filled out the preliminary questionnaire and indicated she would be willing to be interviewed. I recognized her name, as I had worked in the same ward with her for a few months in a hospital, which had closed.

[Notes from my diary as I arranged to interview Doreen]

When I phoned she said she was exhausted, as she had had to visit her son in the hospital after her shift, but that she would be up to an interview later in the week, and we arranged it for Friday morning. She said over the phone that she is disillusioned with nursing, and has found it quite depressing to work where she is now working. I said that this seems to be quite widespread, and that I had gone through a similar depression where I was working. She said it was funny how things happen, that the same day that I (a former co-worker) had phoned, she had to go to [the hospital where her son was, which adjoined the site of the hospital where she used to work] and she said it felt strange going there because it didn't seem familiar, even though it had been so familiar for so many years. She had, in fact, driven right past it. Another funny thing that happened, she said, was that the day before, a woman had brought some lilacs to the ward, and it had made her think of the old hospital, because every day after work, she used to pick a few sprigs of lilacs from a large bush that overhung a back lane near where she parked. She looked for lilacs when she went to see her son in the hospital but could not find them. The next day when she was not looking for them, she suddenly came upon them. I think we both feel happy about meeting together on Friday for the interview.

The lilacs appeared to symbolize a happy time in Doreen's nursing career – they marked the end of her shift at a worksite she liked, doing work that she enjoyed and found fulfilling. They marked a pleasant transition from her working day in the hospital to her life at home with her family. Life was predictable, her home life was organized, and she thought that things would go on like that until she retired. When I talked to her over the phone, however, she seemed different from the relaxed, humorous, intelligent person I remembered. During the interview with her, I heard frequent sighs, tiredness of



voice, and sometimes tears welled up in her eyes. Just as she had apparently almost forgotten the location of the hospital where she used to work, when she went to visit her son (her son had had a minor accident, and was back home by the time we had our interview), she sometimes found it hard to recollect the sequences of some events during the transition to another hospital. It was as though she had tried to forget them – or perhaps the memories provoked feelings of distress and confusion similar to what she had felt at the time. She started her story:

When Gravely Hospital was closing and they wouldn't give us exactly where we were going, we were down to three weeks before closing time – I didn't know where I was going yet, I was phoning the union and the Labour Adjustment Agency almost every day asking what's going to happen, and they always told me "Don't worry, you'll get a letter". It was getting closer and closer to the date when Gravely was closing, and I still didn't know where I was going. Then my live-in babysitter quit. I had to take a year off on a stress leave. So you know how I found out where I was going? I got a phone call – a message on my machine one evening telling me come in the next morning at 7:00. Be at such and such a place. I just about fainted I was so upset. Yeah, that's what I got. This is so and so [name of the charge nurse on the unit where she was to go] just a phone call saying – and not even this is so and so from Western Hospital - and then the ward's name – just the ward's name and I had no clue. I listened to that message over and over again.

Doreen's words reveal feelings of disbelief that is mirrored by other interviewees, such as Dina:

When there is a hospital closed, I think when people are fighting to keep a facility open they're not looking down the road thinking "next week I'm going to be working somewhere totally different". They still haven't accepted that. And that's the big thing. You don't accept it until it actually happens.

Even after 7 years, the closure of this hospital and relocation of its employees was remembered as a change that was involuntary, rather than self-initiated: "I still talk about myself as a Gravely girl. And it's been a long time. I think a lot of them do. I didn't leave voluntarily, so I'm still a Gravely nurse", she said.

On the other hand, nurses who managed to use their initiative to better their

situation during or following the relocation fared better. Vera, a nurse who had to take an extended sick leave after transferring to a new hospital, used her time off work to study occupational health nursing; unfortunately she had to give that up due to funding problems. Someone then recommended that she try working on an extended care floor. At first, she said "Over my dead body", but decided to give it a try. She took a course in gerontology. Much to her surprise, she found that she liked the work, and seems satisfied with things at present. She says that the first transition, from the Gravelly OR to the OR of the second hospital was very stressful, and probably contributed to her illness. The second transition, however, from the second OR to the extended care floor she did not find stressful, as it was her own decision which she made in her own time:

I think the fact of having gone through those two transitions, the one not having a choice and not knowing was the hardest – the no control. Whereas the situation where I controlled my own destiny by choosing where I would go made it a much easier transition.

Some nurses found that the closure and relocation experience made them more empathetic to people experiencing new situations: "Makes me kinder to students. Much kinder", said one.

### Problems Fitting In

After relocation, nurses often had difficulty fitting in at the new hospital worksites and many perceived that the nurses in the new hospital resented or were impatient with them. As Dina said:

People resented them coming in. At X. Hospital on the ortho floor, the team that went there were all seniors so they were very resented there. They took their seniority with them, so there was a lot of ill feeling there at first... You're sort of uncomfortable, because you don't know the routines, and everybody else is very comfortable in their job... There were a couple of incidents with other nurses that we had to call the union

Doreen saw the transition period as a difficult one for the nurses at the new place also:

So they had a big influx of Gravely nurses all at once, it seemed. . It was really hard, and it was hard for the nurses at Western Hospital, too. And then we came in after having gone through a lot. So there was a lot of sorting out of feelings and things to get through.

There was a sense of betrayal for those who believed they had been lied to by the representatives of the hospital and the government: "They said that the hospital [that was closed] could not be brought up to safety standards - that was a lot of hooey. That was just a falsehood", she said.

### Unresolved Grief

Unresolved grief was a salient theme in many of the interviews with nurses from Gravely, or from other hospitals that had undergone drastic changes. One nurse was said by her friend to be "still in mourning" from the change. Renee, who had experienced "restructuring" in Ontario, and then moved to Vancouver, was now working in a hospital where amalgamation and other changes had taken place, and where it was rumoured more drastic changes were about to take place. She said:

Some of the units were really feeling stressed, yet they would say – some of the VPs would say, "you just need to let go, you just need to move on". But again, I don't think people can move on if they don't deal with their feelings. You're grieving – it's like a grief, it's almost like a grief, loss of X Hospital as it was, but not – we're not at the future yet, right? You've lost – again it's that loss, – I think you need to acknowledge how upset you are. There's a huge impact on nurses when you do anything - call it regionalization, call it restructuring, whatever. [They] need to support nurses. Nurses will go, they are not bound anymore, they have options.

Renee referred to Lewin's (cited in Ross & Nisbett, 1991; Barker, 1993) concept of the three stages of change: unfreezing, moving, and refreezing. Citing Lewin, Barker (1993) stated that during the implementation of TQM at the plant where he carried out his research, the unfreezing phase began with "chaos" when the supervisor introduced abrupt change; then "normative rules and value consensus" emerged and were

consolidated; and lastly, new rules were formalized and stabilized. To make sense of what was happening, Renee had recourse only to similar managerial "discourse" in the hospital where she worked, in which the actual lived experiences of nurses was erased.

### "The Whale Swallowing the Fish"

Nurses working in smaller hospitals that amalgamated with larger hospitals, perceived themselves to be subordinate to the administration of the larger hospitals, and they considered that the smaller hospitals had lost autonomy. As Renee said:

It's time to swallow up places. We are being taught to do things how X. Hospital does it, because we are now under their umbrella. You're almost like a little fish; you've been swallowed up by this massive whale. So whatever they say has to be done. They lose some of the autonomy they had. We've changed our name, twice, three times, since I've been here.

They also considered that staff in the large hospital to which their hospital was affiliated had preferential access to jobs in the organization as a whole, and more opportunities for advancement. They perceived that staff at the large hospital considered work at the smaller hospitals less desirable, less challenging, and by implication, the nurses at the small hospital less skilled. As Renee explained:

Some staff from the bigger hospital "put in their time" at the smaller hospital, and then go back to a fancy position. We're good enough for some of them to be put to pasture here, but we're not good enough to go there.

Jean, a manager, was "let go" in 1995 along with two other managers, after the merger of her hospital with a larger hospital. One manager who was completing her MSN was retained for two floors, while a new manager from the larger hospital was brought in for the other two floors. From interviews with nurses from other amalgamated smaller hospitals, the replacement of a manager in the smaller hospital by one from the larger hospital seems to be a common pattern

### Marginalization from Events

Nurses expressed feelings of marginalization from events. A nurse working at a small hospital told me that they knew "something was up", because they had seen a group of VIP's -people wearing suits and name-tags - touring through their floor and adjacent floors. It was rumored that a sub-acute care unit was going to be moved from the large hospital to the smaller hospital. Members of the front-line staff, however, were passive bystanders of events as they unfolded, and at best got information through the "rumour mill" and often from sources outside the hospital. There was a constant vigilance for clues and meanings to be gleaned from the occasional arrivals of members of administration and important-looking outsiders. My experience one day illustrates this. Wearing smart street clothes, I interviewed a manager of an acute care floor where I was going to be doing participant observation. This hospital had undergone changes in administration, and it had been rumored for over a year that more changes were imminent. When I walked into the foyer of the hospital with the manager, who was going to show me how to access the extended care unit, a small group of staff in the foyer watched us intently, wondering who I was and why I was talking to the manager.

### Continuing Uncertainty

As we look to the future and ways to improve our service to health customers down the road, we are aware there is a concern right now in our communities that the health system of today will not be around in the future. (Hospital Special Bulletin, June 2002)

Long after the "transition period" at the beginning of restructuring was officially over, an air of uncertainty and chaos continued to prevail in hospitals, as the process of restructuring took different turns. One nurse in a smaller hospital said:

Then the talk more or less evolved to that they were going to have all ambulatory clinics move here. So it would be an ambulatory building of some sort. So there's always a lot of uncertainty in what was happening. Now a lot of people are uncertain about their position, because they're not certain about the long-term plan for the hospital, and do they want to work here just for several months and then finally have to go and find another job, and it could happen.

Renee, who also works in a small hospital, said:

In Ontario we'd already been trimmed down to the bare bones so how could we possibly do anything else? Because I was unionised, they kept saying, "Well, if something ever happens, you're unionised, so nothing will ever happen to you". But there's always a lot of uncertainty in what was happening. We were in a period of chaos. This feeling of chaos has lasted a little bit too long

One nurse who had been transferred from one hospital to another described a series of confrontations between herself and the manager in the new ward where she'd been assigned, which ended by an apology of sorts from the manager, who said "well, you realise we're going through some bad times here".

Another nurse in a larger hospital, who had graduated one year before the interview described ongoing changes about which she was trying to feel optimistic:

We're also in transition. Our manager is trying to create two new positions of patient services coordinator and removing the charge nurse from the desk and making these other two positions. And that's a really big source of conflict on the ward right now, because I think we see our manager talking about this new position as basically being an administrative assistant's job. We're saying we need the hands on, the person at the desk, somebody involved in consistent discharge planning to make sure our patients are taken care of. I'm really trying to be optimistic about this position because I'm young and I think that there's nothing the matter with change and trying something new.

### Health Care Becoming Like a Business

Subject: Future Plans for an Enterprise-wide business system. To inform all hospital staff members of our plans to implement one common regional business system and the opportunities that can be achieved through this initiative. The need to establish one regional business information system – encompassing the broad functions of human resources, payroll, finance, logistics and decision support. A regional system will not only improve the efficiency and effectiveness of our operations, it will support the need to integrate a higher level information, enhance data analysis, and establish standards for reporting and business process [Memorandum to all hospital staff from CEO, May, 2002].

We need to continue to build on the strength of this consolidation while still respecting the local needs of customers through our Health Service Delivery Areas [Special Bulletin, June 2002].

"It's not altruistic anymore," said one manager about hospital nursing and health care. More than a few nurses appeared cynical about the health care system, describing it as becoming more and more like a moneymaking business, rather than motivated by altruistic caring. Said one nurse:

I love nursing but I hate going to work. I just think the hospital is not conducive to caring. It's just like a business; it's like a market. In and out. Who cares about caring? We're not here in the hospital to care for you. We're here to do your dressing, give you surgery, and out.

Vera, an OR nurse said

And so time is money, so it's faster, faster, faster, the faster you move the more money they make. Unprincipled. Well, I guess that's the age we're in. Everything is handled like big business.

In front-line nurses' narratives about restructuring many felt cynical about the terms used to describe and make palatable new styles of management such as Total Quality Management and Patient Focused Care, that the managers were responsible for implementing. As one nurse said, "They [head nurses] were caring people...but now [managers' attitude is] 'Our focus is on the patient' and not the nurse". Said another, "Right now it's like a big business. Just produce. And we just carry on. And they don't care about you as an individual. Or they pretend to but they're not sincere, they're not honest".

An article by David (1999), who studied nurses' conflicting values in "competitively managed health care", was pinned to the wall in a medication room of one hospital floor. I copied the article and then pinned it back on the wall. David (1999; p.188) said that in the U.S., "a philosophy of health care as a business is threatening the complex human interactions that are essential to nursing", and that nursing is now practiced in an environment that restricts understanding of its value and purpose. The

points she makes apparently resonate with nurses on more than one hospital floor.

The narrative theme of "Health Care Becoming Like a Business" could have been placed instead in the following section under the title "Ethical Dilemmas". Like the dilemmas now presented, it involves front-line nurses who must carry out tasks in an environment over which they feel lack of control, and in which they perceive their personal beliefs and ethics to have no value or influence.

### **Ethical Dilemmas**

Problems with ethics and ethical dilemmas on the hospital floor have given rise to a new field of study in nursing and in medicine which includes "end of life decision-making" (for example Rodney, 1997; Starzomski, 1997). Hospitals have ethics committees, as do universities for ethical practices in research. From the 1970's to early 1990's this was in large part due to technological advances that have made possible the extension of human life long past the point at which many would consider that life no longer has quality. In the mid to late 1990's, however, this took a new turn with the advent of "cost-containment", referred to in the previous section as "health care becoming like a business". Some nurses reported that in the early 1990's they noticed that medical residents were starting to take into account the cost of procedures and pharmaceuticals before they ordered diagnostic tests and medications. By the mid 1990's, it was evident that cost was becoming a factor in decisions around who got what care – even in some cases, who got resuscitated and who did not. Yet, this appeared to remain arbitrary at times, which is evident when comparing the following stories of "Tube feeds", and "The ventilated cancer patient" with "The code that was not



a code". Five examples of ethical dilemmas encountered by nurses in the study are now described.

### Tube Feeds

A number of nurses from Extended Care said that the issue of tube feeds was causing them distress. One nurse said that she hated to see elderly stroke victims, often elderly Chinese women, being fed enterally through a tube into their stomachs. She thought that they did not look happy, but they could not make their wishes known due to a stroke or language barrier. She saw the patient/resident lying there "getting fatter and fatter", and from her point of view, there was not much quality of life for the resident.

So your own sense of right and wrong, and your own concepts of what should be done here, it's right onto what's being done. And you have to withdraw from your own feelings of discomfort, and look after these poor unfortunate people. We've been trying to address that at our level, but we can't get anywhere, we are getting ridiculed. Every time we question it, we are being diminished. I just have to talk to myself at the bedside and say "It's too bad I have to do this to you, Grandma, I'm really sorry".

In another interview, a nurse said that there had been a family meeting between a resident being fed enterally (a man in his 60's), his wife, the manager, the social worker and the charge nurse. This man had apparently always tried to pull out the tube, so that his hand had to be tied. At the end of the meeting, they had decided to discontinue his tube feeds. There was consternation among the staff, who went to look at him every day, as he became more and more emaciated. The interviewed nurse said that one night at home her sleep was broken as she "sat bolt upright in bed" with the image of this resident before her eyes.

On one ward where I did participant observation, a young male resident in his late 30's or early 40's lay comatose in a private room due to having been severely

beaten in a drug-related incident. He was in a private room due to carrying Methycillin Resistant Staph Aureus (MRSA). On the wall was a picture of him in better days: a handsome smiling dark young man in an expensive suit, surrounded by pretty women. Now he lay thin and unrecognizable, with a tube feed to his stomach, coughing explosively now and then. Nobody ever came to visit him. Nurses and PCA's did not like going into that room, where they had to put on gowns and gloves before entering, to wash and turn him, or administer enteral feed and medications through the tube. I never heard staff talking to this resident.

From Iris' point of view, she had to participate in what to her was an inhumane practice of forcing patients to live interminably in a state of suspension from normal human activities like eating, drinking, and talking. Not being able to find out the patients' wishes in the matter was distressful. Yet, she and a co-worker felt "ridiculed and diminished" by other members of the "team" when they tried to confront the ethical dilemma. Similarly, Jane was censored for "doing her own thing" when she tried to assuage her feelings of ethical distress by flushing the patient's tube with warm water instead of with Normal Saline, described in Chapter Five. In order to be thought of as "good [competent] nurses" it was necessary for these nurses to "withdraw from their feelings of discomfort" and demonstrate that they were capable of following orders flawlessly.

### Sedation of the Elderly

Some nurses in extended care consider that most of the elderly residents receive too many unnecessary medications. Of particular concern is the issue of possible over-medication. Thelma pointed to an elderly woman sleeping while sitting in a wheelchair

in the dining room, her head lolling to one side. She said that the woman had been anxious and agitated when first admitted to the floor, "and now look, she can't even eat on her own". She blamed another nurse who had lobbied to get sedatives ordered for this resident. "They kill their spirit", she said, "and it makes me sick". Most of the residents in the dining room of this facility were sitting quietly in their wheelchairs, either napping, watching the TV, or staring out the window or into space until meal trays arrived, until activities such as the walking program began, or until their care aide arrived to take them back to their room to get ready for bed. The occasional resident became noisy, shouting repetitively, which caused some nurses to be visibly upset or nervous. Usually she would then administer some "prn" (medication ordered to be given "as necessary") sedation, and wheel the resident back to their room. The stated policy of most long term care facilities is to use sedation only as a later resort, after trying other interventions such as offering a cup of tea, checking to see if the resident is in pain, or needs changing. In practice, however, nurses work out a compromise between the stated policy and the needs of their co-workers and themselves to have a quiet dining room, and a compliant resident who does not fight and hit out at the caregivers. In each case, however, some nurses feel distress due to the noisy resident, and/or to the prospect of over-sedating the elderly, or to possible censure from co-workers for not administering the drug. Drug addiction in patients, described in the following section, also causes distress.

#### Drug Dependent Patients

The type of patient population is sometimes distressing for nurses, as illustrated by Donalda, who works in acute care. She had tears in her eyes as she related an

incident with a drug-dependent patient and visitors. It is noteworthy that this nurse had been transferred to her present position after the closure of another hospital.

I popped my head out of the curtain and said to them "excuse me, this is a hospital, could you lower your voices a tiny bit, please?" They just swore up one side of me and down the other, called me everything under the sun and who does she think she is telling us to keep our voices down, and they kept it up. My blood just boiled. I thought "I've been working for so bloody long trying to do something good for everybody, and they're going to swear at me like that? If I let them get away with this, then I might just as well lay down and say "Walk on me". I went out into the hall, and said to the charge nurse "Jerry, I'm having trouble with these people" and I thought I was going to pass out, I got so anxious, that honestly, I thought I was going to pass out, my legs buckled and I grabbed hold of the rail in the hall, and I went into the bathroom, and sat down and started crying. I was just totally.. exhausted by the whole thing, like I just could not believe that this was really happening, you know? They phoned security and it went on and on, and I got myself together after awhile, and I said [to the other nurses] "I'm sorry you guys", like it caused a big commotion on the floor and I could have just kept my mouth shut and let it go, as normally is what happens. But you know [voice becomes faint] I'm so tired of this, I'm so tired of listening to them swearing and saying terrible things, even if it's not at us, but just at their whole – [life situation]. There are other people in the room, sick people, they visit till all hours of the night ...nobody seems to say anything to these people, they just leave them to do as they please, because it's..easier, I feel. ..It's just easier not to say anything, it's easier to just go through your day, get your shift over with, and try not to notice too much what they're doing. One doctor said "Well, you know, they are entitled to medical care and we can't really discharge them" and I said "You know what? Where's my right to come to work and be safe?"

Donalda said that when she first started nursing, she loved caring for people, and she still does, but that she hates going to work. "Something has happened and it shouldn't be like that", she said. The "something" that Donalda is referring to originates externally from the hospital. It refers to chaos and change over which nobody seems to have any control and which manifests itself in her working environment as drug addicted patients who are its symptom. The only other kind of patient more dreaded on an acute care floor than the drug-addicted patient, is the patient who has stopped breathing or has no pulse, and who must be resuscitated. This event is now described. It sets the stage for a description of ensuing ethical dilemmas, in which decisions to resuscitate or not to resuscitate are not clear-cut.

### "Calling a Code"

"Calling a code" refers to finding a patient in cardiac and/or respiratory arrest, and then calling the "code team" to the floor to resuscitate the patient. It is the most dreaded event by nurses on acute care floors. It is also dreaded in extended care, but since it is quite rare in ECU, the dread is not ever-present as it is in acute care. Most patient residents in ECU are "no code" status, and those who are "full codes" (mentioned with apprehension) are dispatched to the ER at the first sign of serious illness.

One ICU nurse, Helen, said that some nurses even in critical care avoid a "code":

We've had people there for 20 years, who don't want to do it, and refuse to go to the code updates and all this kind of stuff. I guess they don't feel confident enough. It's not that big a deal. It's the stress level, is more what it is. And some of these people were never high-powered people to begin with and they were in ICU from the very beginning.

Helen's normative statement indicates that a "high powered" nurse in ICU should not only take a "code" in stride, but would even welcome any opportunity to take on "the sickest of the sick": "You don't usually get that many really sick patients all at the same time. And if you do, there are very many dynamic people there who really like those type of patients", she said.

A typical code scenario is now described:

A nurse goes into a room and finds a patient lifeless-appearing, not breathing, and perhaps without a pulse or she witnesses the patient going into cardiac arrest or respiratory arrest. She calls out for help, presses the emergency button on the wall behind the bed and starts cardiopulmonary resuscitation (CPR). The person who

responded to her call for help goes back to the nursing station, dials a special code number to the switchboard, the switchboard operators activate the beepers of the code team, and announce "code blue" over the hospital PA system. "Calling a code" is the most dramatic and dreaded event on an acute care floor. Every nurse hopes that it won't happen on her shift. A "code" epitomizes in a moment the fight for life over death in the hospital, and when a code is called, a number of designated people become highly alert, adrenalin coursing through their bodies, as they carry out in real life, actions that they have rehearsed many times in drills. Nurses on other wards hear the PA announcement and say or think "Oh, oh - a code on Floor A". They empathize with the nurses on Floor A and are glad it is not on their floor. Later if a float nurse familiar with Ward A encounters a nurse from that floor in the cafeteria or waiting for the bus after work, they may ask, "Who [which patient] coded?"

Beepers carried by the code team give out a beep sounding like Morse code, which is followed by a hospital-wide announcement from the switchboard over the PA system: "Code Blue – A Floor; Code Blue – A Floor". On the ward itself, a loud siren-type alarm sounds. If one is in another part of the hospital, one can often hear feet pounding down the halls from different directions of the hospital, as residents, MSI's, the ICU nurse with the red code cart, the RT, the code porter, the IV nurse, run at top speed to A Floor. The nurse who has discovered the patient in arrest has started cardiopulmonary resuscitation – with bag and mask she forces air into the lungs, alternating this with chest compressions – often hopping up on the bed beside the patient in order to be able to exert enough pressure on the chest. She doesn't do this for long, however, because to her relief, the code team arrives within minutes and takes

over. The second ward nurse – the one who alerted the code team through the switchboard - has started documenting on the code sheet succeeding events: who started ventilations at what time, what time compressions started, how long it took the code team to arrive, who administered what medications, the rhythm on the monitor. The ICU nurse usually arrives first, attaches electrodes on pads on the patient's chest to a portable cardiac monitor, which instantly shows a running diagram of the electrical activity of the heart. She slaps on two soft, rubbery rectangular pads onto the parts of the chest where she is going to put the paddles of the defibrillator. If the rhythm on the monitor is ventricular fibrillation or ventricular tachycardia, she calls out "stand back!" and administers a shock from the defibrillator. Sometimes this instantly puts the patient back into a regular (or at least a viable) heart rhythm. By this time, the rest of the team has arrived, and the head of the code team – a physician – takes command. Different medications are called for, administered by the ICU nurse (or sometimes a resident) who announces that it has been administered, and the recorder writes it down. The physician or resident may decide to insert an endotracheal tube (ET) down the patient's throat – an extremely tense moment in the room – and then the RT bags the patient through the tube, synchronizing this with whomever is doing chest compressions. After about 30 to 40 minutes (rarely as long as an hour), the patient has either survived, or the code is called off. If the code was successful, the patient is transported bed and all, to the ICU and attached to a ventilator in the ICU if still not breathing spontaneously. The ICU nurse and the recorder go over the record. The empty space in the room where the bed was is strewn with discarded wrappings from central lines, ET tubes, suction catheters, along with perhaps a blood and mucus-streaked ET tube that was

not the right size, old oxygen tubing and nebulizer tubings, syringes, needles, gauze pads, and a full garbage can. If the code was not successful, the code team quietly and rather dispiritedly stays around the nursing station for awhile, discussing the code, writing in the doctors' notes, assembling strips from the monitor, while one or two nurses go into the room to clean up the mess and make the patient presentable before relatives arrive.

### The "Code" that Was Not a Code

On an acute care floor one day, a nurse "called a code" when one of the patients she was caring for went into respiratory failure – that is, the patient's breathing had become very shallow and laboured, and she was losing consciousness. The nurse first described the background to what happened:

Yesterday, I called the family doctor for Mrs. X because her family said that she was in pain, and she looked in pain. The doctor ordered morphine, and said that we must discuss with the family in the next day or so what kind of treatment they wanted to continue with. I gave her 15 mg. morphine, and the night nurse gave her morphine syrup for "breakthrough" pain, and 15 mg. morphine the next morning at 0600. When I got on the next morning, her daughter said that she was feeling pain. I gave her some more morphine syrup at 0815 for "breakthrough". The daughter came to me and said that her mother was very drowsy. I explained to the daughter that it is a matter of "finding the balance": enough morphine that she doesn't feel pain, but not too much so that she is too drowsy to talk. The daughter went home.

Susan has assessed the pain level of the patient and given enough morphine so that the patient is no longer feeling pain. The patient's code status – what level of intervention is to be taken if her condition worsens – is called into question in Susan's mind, when the doctor said they must discuss it with the family "in the next day or so". Nobody, it appears, is expecting the patient to die imminently. Also noted in Susan's mind is the daughter's worry about her mother's drowsiness. She checks the patient's Oxygen saturation and finds it satisfactory.



It was in my mind that Mrs. X. had a "do not intubate" order on the Kardex, but I was faced with – well, it also seemed that no one expected her to die any time soon. So later that day, I had to make a judgment call. About 1400 her son came up to the desk and said "There is something wrong with her breathing". I went to check, and saw that she was having labored shallow respirations, and on auscultation, was moving very little air. I got an oxymetry reading and found that her O2 sat. was only 68%, even when I turned the oxygen up as high as I could with the mask. I went into the nursing station and asked the unit clerk to call the RT, the CTU resident, and Dr. S., or whoever was on call. I told [the charge nurse] and she asked me if I knew where the bag and mask are, and I said I did. The RT put a Star Wars mask on the patient, but it wasn't helping. [The charge nurse] said over the intercom [to the patient's room]: "The CTU resident will be up in two minutes". The CTU resident Dr. J. arrived. I told him that I didn't know if it was the morphine or not. He said "I don't want to intubate her". "No" I said, "but we have to do something or she's going to arrest. Dr. S was going to discuss things with the family."

As Susan, the resident, the RT, and the son watched, the patient became unconscious.

Mrs. X.'s O2 sat. kept dropping and she went unconscious. I said to Dr. J. that I think we have to call a code. He didn't say anything. I had been charting everything in Mrs. X.'s chart and I stepped out into the hall still holding the chart, and said to [the charge nurse] at the desk "Would you please call a code?" The code team arrived very quickly and bagged Mrs. X., with an airway in; they asked me how much morphine she had had and I told them. They gave her 4 mg. Narcan. Mrs. X.'s O2 sat came up to 89, she opened her eyes, and talked to her son. The doctor explained to the son that she was doing very poorly, and he had better call the family "the sooner the better". A lot of family members arrived, and gathered around the bed. Mrs. S. was sitting up in High Fowler's, looking up at her family members, smiling, looking happy and comfortable..

Susan felt satisfied that she had done the best she could to make the death as happy as possible, and as acceptable as possible to the family. She was not aware, however, that other staff members did not share her perception until she had a meeting with the manager of the floor a few days later. I interviewed Susan shortly after her meeting with the manager, taping and transcribing the interview.

Susan: [the manager] said to me "Now promise me you won't get defensive about what I'm going to say. You remember Mrs. X last Friday in Room 123. She had already been a "no code", but you called a code on her, and the Emergency doctor was very upset about it, and so was Dr. J. [the CTU resident] and Dr. T. [the Family Practice doctor on call]. Dr. J. says he asked you if she was a code and you told him 'Yes, she is a full code'".

At the beginning of the interview the manager has established the rules of the interview. Anything Susan might want to say about the incident is out of order because it would be

“defensive”.

Susan: I told her “this is not true”, but she didn’t want to hear anything I had to say about it. She said “One should have it memorized who is a code and who is not...it is a waste of resources, and the emergency doctor was very upset about it. Then there are other concerns I have about it. Josephine, who was charge nurse that day, said that you asked her very casually, holding a clipboard in your hand, to call a code. Another thing that is wrong is that you went out into the hall to find someone to call a code, instead of staying with the patient; it doesn’t matter that Dr. J. was with the patient, you should have stayed with the patient and pulled the alarm bell at the bedside... So some nurses are beginning to question your judgment”.

“The code that was not a code” demonstrates a number of issues surrounding hospital nursing work, one of which is the ambiguity that often may surround the protocol of designating “no code”. Usually the doctor writes a “no code” order on admission of a very elderly patient or a patient with a poor prognosis, so that should the patient suffer cardiac arrest or respiratory arrest, they will not be intubated nor resuscitated by a defibrillator. The order is then transcribed onto the Kardex (for an example of a Kardex, see Appendix E), and checked by the nurse. From time to time, the “no code” status may be changed, and the Kardex updated.

The decision to assign “no code” status to a patient is usually arrived at through consultation between the doctor, the patient, and the family. The usual reason for this order is to spare the patient the indignity of CPR when it is evident that he or she would not survive much longer even with CPR. Some nurses have said that when they have carried out chest compressions on elderly patients during CPR they have heard and felt the patient’s breast bone and ribs break and crush. Nurses have described this as a very distressing event. On the other hand, withholding CPR when the nurse interprets that it should be carried out is also distressing for the nurse.

The nurse in this case was aware that the family members did not expect the patient to die imminently, and that they clearly expected staff to do something about her

insufficient respirations. The nurse had noted the “no code” note on the Kardex, but perceived a discrepancy between the “no code” order that had been transcribed on the Kardex, the expectations of the family, and the statement by the family doctor that “We will have to talk to the family to find out how they want this patient treated”. In other words, as far as the nurse knew, it seemed that the family had not agreed to it. In addition, it appeared that there had been little or no discussion among the health care professionals involved with this patient about her “code status”, so that there was no common understanding or agreement about it. Adding to the ambiguity about the appropriate level of care for this patient was the fact that she was receiving regular antibiotics through her IV, which one would not expect if the patient were about to die.

In the scenario of the “code that was not a code” there is also ambiguity about giving and receiving directions, and about lines of authority. The resident doctor who had been called to the patient’s bedside was evidently not familiar with the patient’s history, but he apparently did not ask the nurse about it, nor read the patient’s chart which was in the room with them. He said “I don’t want to intubate her”, but at the same time did not say with certainty that nothing should be done, and did not object when the nurse said she was going to call a code. The possibility of intubation, which possibly he dreaded or had never done before, was obviously foremost in his mind as he was called to the bedside. When the manager asked him if he had asked the nurse about code status, he said the nurse had told him the patient was a “full code” (which the nurse denied). It appears that he was using a tactic to avoid blame and censure for his part in the “code that was not a code”, and deflect blame onto the nurse (not an unusual tactic in the hospital, some interviewees have pointed out). The RT also did not give any

opinion about what he thought should be done – he merely applied a state-of-the-art Star Wars mask, turned up the oxygen to 100%, and measured the O2 sat. The charge nurse did not come to the room to confer with the nurse or give her support, nor did she make an effort to sort out the code status of the patient. She called the resident on call when she was requested to do so, and then called a code when the nurse requested it. Later, on discussing the event with the manager, she told the manager that Susan had broken the rules by leaving the patient's bedside, and that Susan had used an inappropriately casual voice and manner when she requested that a code be called.

From the perspective of the nurse, the scenario ended ultimately with a dignified, proper, and peaceful death, due at least in part to her own interpretations and interventions. Possibly the patient and family thought so too. From the perspective of the other medical and nursing personnel, however, it was a very annoying waste of resources and should not have happened. By "waste of resources" they meant waste of adrenalin and effort as well as waste of manpower, time, and materials. The easiest and most identifiable cause of this waste of resources was the apparent oversight of the nurse who called a code when the patient was a "no code".

The fact that the nursing manager - not the resident's supervisor - asked Dr. J. if he had checked the code status with the nurse contributes to ambiguity about lines of authority, and possibly hints at the eroded authority of medicine versus nursing. Lines of authority were also ambiguous when the resident left it up to the nurse to make a decision about the code. The fact that the resident could later deflect blame onto the nurse, however, could indicate that nursing is still subordinate to medicine. On the other hand, the questions put to him by the manager could have led him to make the

allegation.

The manager did not perceive an ethical dilemma in the event. Rather she saw it as a waste of resources, as the emergency doctor did. She had to do "damage control" - assuaging the anger of the ER doctor by deflecting blame from her ward and onto the individual nurse. (Normally the ER doctor would not be called to a code unless there was no other doctor capable of intubation, available for the code team). The manager did not examine the event any further. She did not ask the nurse about it, and apparently did not make suggestions to the charge nurse as to how things could have been done differently.

Some of the ambivalence and transition about codes is illustrated by the phenomenon of the "slow code." When, in the consensus of staff members, a patient is inappropriately categorized as a "code", the staff will literally walk slowly to the code button to sound the alarm, make desultory motions to do CPR, and the code is typically called off moments after the code team arrives. Through the tactic of the "slow code" the nurses and doctors in unspoken collusion confront the ambiguity and avoid the disturbing ethical dilemma of performing CPR on a patient they know will not survive it.

Besides illustrating ethical dilemma, the long quotations in the "code that was not a code" illustrate the nature of work on an acute care floor, in comparison to the other levels. The scenario described by the nurse in the "code that was not a code" vividly illustrates a number of issues in nursing work, including the intensity of ethical dilemma often faced by nurses; the ambiguity sometimes attached to "code status" of patients; the importance of "ethnological competence" (Leidner, 1993) in nursing; and how policies of cost containment have impinged on these issues.

### A Ventilated Cancer Patient

In this section, distress among nurses is described when a woman with terminal lung cancer was on a ventilator for several months. Many interviewees in this study describe “heroic measures” on the elderly or dying as morally distressing. Again, the dilemma is the result of the nurse having to carry out actions decided by other professionals that she feels are not in the interest of the patient, or are contrary to her own value system. One nurse related in remembered horror the story of a woman patient around 65 years old, who had been resuscitated after suffering a respiratory arrest on a ward a few years ago. The patient was intubated and rushed to the ICU, where she remained for months on the ventilator until she finally died. It was not until after she was intubated and on the ventilator that medical staff diagnosed lung cancer. On the insistence of the woman’s sister, to do “everything”, and due to the lack of clear-cut policy guidelines for “end of life decision-making”, members of the medical staff were reluctant to take responsibility for and give the order to disconnect the patient from the ventilator. The patient appeared more and more inhuman and corpse-like to the nurses who cared for her week after week. This same nurse related another story in which the opposite dilemma presented itself. An elderly man with “terminal” chronic obstructive lung disease was brought to the ICU, and although his wife wanted him to be ventilated, medical staff deemed it inappropriate.

Some nurses have tactics to overcome the dehumanizing aspect of technological interventions:

I tell every family member who’s going to get out of ICU, like when they get better and they’re out of the hospital, bring them back so we can see them; it’s funny though when you see the patient, they come back, you recognize their family members, but you don’t recognize the patient because they have clothes on, and they’re not swollen (Ranjit).

In extended care there are more precise guidelines and limits that physicians follow in deciding whether or not to resuscitate and/or ventilate patients whose prognosis is considered hopeless. For example, a young man from an extended care floor with advanced multiple sclerosis, whose mother wanted "everything to be done" when he developed pneumonia was not ventilated, and died on the acute care ward. In all patient charts in Extended Care, and in most charts in Palliative Care, there is a page with "Levels of Care" designated from 1 to 4, with one of the levels ticked off and initialed and signed by a doctor. These levels progress from "comfort measures only" to "antibiotics and hip operations but no ICU", to "resuscitation with defibrillators, but no intubation", to "full CPR including intubation". Despite these attempts to codify "end of life" decisions, however, they remain ambiguous on the acute care floor - as the "code that was not a code" illustrates.

Thus decision-making about "code" or "no code" status in the hospital is changing along with other aspects of the health care system in this period of "cost-containment" and restructuring. Previous to the present period of restructuring, the development and application of medical high technology seemed limitless, which sometimes presented unpleasant situations for nursing staff (and no doubt the patient) like that of the woman with lung cancer dying a slow death on the ventilator. Recent revisions to decision-making protocol regarding patient resuscitation may prevent the inappropriate use of high technology in such cases. On the other hand, resuscitation decisions now appear to be influenced by the factors of "cost-containment" and "allocation of resources" - which appeared to be a main concern of the manager in the case of "the code that was not a code". Meanwhile, the front-line nurse must still carry

out actions and calls dictated by a Kardex, or some one else's decision-making that from her point of view may appear arbitrary or inappropriate.

Dread about the potential for having to "call a code" is widespread on acute care floors. It is in the back of nurses' minds during interactions concerning medication errors or other errors, and when they suspect that a member of the nursing working group is unreliable. It contributes to the increasing tension felt on the floor prior to and during a targeting episode. This is illustrated more fully in Part Three, which follows.



## **PART THREE**

### **“EVERYTHING IS POLITICS”: PROBLEMATICS OF INTERACTION**

#### **Introduction**

“It’s much more political, especially in the last 5 years, than it used to be.” [Helen]

While Part Two was mostly descriptive, it provides the setting for Part Three, in which the focus is on interactions among members of the nursing working group and which contains more in depth analyses of those interactions. It will be seen, for example, that the narratives of restructuring and ethical dilemmas recounted by nurses in the preceding chapter have a distinct bearing on their concerns about competence, which along with the theme of “politics” is an equally salient theme permeating – even dominating – the thoughts and interactions of front-line nurses as they go about their everyday work. Concerns and anxieties about competence, along with uncertainties brought about by restructuring, sometimes translate into dysfunctional interactions like targeting, that are thought of as being part of ward “politics”.

The rest of the introduction to Part Three is a discussion of the meaning of the theme of “politics”. Chapter 7, which follows, is a discussion of the surveillance and management of competence on the nursing floor. It begins with issues around operationalizing competence, and a discussion of how surveillance for competence takes place among nurses themselves. The socialization and surveillance for competence directed to new nurses, it will be seen, is often perceived by them as hostile, often even when the nurse clinician – the new on-site manager of competence – is involved. Surveillance sometimes then escalates into targeting episodes, as in

Kathy's story. Two case studies of targeting episodes – "The Social Construction of Incompetence" – are presented in Chapter 8, which ends with an in-depth analysis of the case studies. In Chapter 9, the final chapter of Part Three, tactics of solidarity among nurses and their resistance to targeting and restructuring are explored.

As previously mentioned, "politics" is a ubiquitous theme in this study. Most front-line nurses referred to this phenomenon in the context of dysfunctional or unpleasant interactions among members of the working group; while managers, a nurse clinician, and some front-line nurses related "politics" to hierarchical relations within the hospital. Val defined it as "ward politics means whose word is most powerful - something like that". Almost all interviewed nurses mentioned the phenomenon of "politics" in the hospital as something negative in the interactive environment that most would like to avoid. For example, Shauna said about her co-worker who had been involved in a targeting episode:

Looking at her and seeing her, I kind of feel that – like she just wants to stay out of the whole dynamics of politics of the whole place, and just do her own thing. I can see that she just wants to do her job the best she can and just go home.

Some nurses chose to work night shift or on a casual basis to avoid politics. Kathy, a nurse originally from the U.S. and not familiar with the term "politics" instantly recognized the phenomenon when I said "some people work nights to avoid politics".

She said

It's the peer politics that are hard. You can handle it when you're not being supported by the hospital as a whole, or maybe you're not being supported by your manager. I mean, it's awful, but you can handle it. But when you're not being supported by your peers, that's devastating. We need that support.

"Politics" was mentioned in a matter-of-fact manner indicating collective understanding of its meaning, but when pressed to define it or to give an example of it,

most nurses hesitated or had some difficulty. The following excerpt illustrates:

Emma: The politics of being in any one place for any given amount of time is that you learn them, and that's not my favourite part of nursing.

Q: What does politics mean to you?

E: Well, the nurses sit around and complain that the linen carts are never full, but there's no way for us to ever get any more linen. We complain about the staff that continually call in sick on weekends, like repeatedly over and over. We talk about how some of our colleagues come to work dressed like they should be heading to the beach and how unprofessional it is. They feel that our manager is too wound up in - whatever - to seem to get a handle on some basic simple issues on the ward. We're a self scheduling ward, so tensions run high - 40% of the people try to make it work, and 60% of the people write their initial choices in and then don't change a single shift.

Q: So it means bitching and complaining about issues that are not resolved?

E: Both things. One of our nurses wanted to go back to school and do her ER training and our manager refused to give her a leave of absence. She granted other leaves of absences for people to go on long vacations. Well, this nurse ended up having to go to the vice president of the hospital and have the hospital give her an unpaid leave of absence so she could keep her seniority.

By referring to politics as something you learn if you stay for any length of time on one floor, Emma indicates that it is a set of unwritten and unspoken rules and norms indigenous to specific working groups that binds its members, often involuntarily, to certain behaviours. Apparent arbitrariness and favoritism by the manager toward members of the working group is included in the definition. Though the rules and norms of working groups are indigenous, they are nonetheless subordinate to and dependent upon those of the higher hospital hierarchy for their continued observance. Louise, a nurse clinician, said:

There were several issues not related to restructuring but related more to just politics in the hospital. I and a couple of other people in a similar position as me had tried to go to [an administrator, with the issues] but I think she was unwilling to take that one on, because they were a little too political, which led to our resigning.

The rules and norms of the higher hospital hierarchy are not usually known to front-line nurses or even to managers. One former manager, Janice, said that the new type of

management is "sneaky, political, and one doesn't know what is going to happen next".

Kramer (2000; p.47) defines organizational politics as "the use of social influence behaviors that promote individuals' goal attainment" within organizations. Bacharach and Lawler (cited in Kramer, 2000; p. 47) define it as "the efforts of social actors to strengthen or defend their power positions and to exercise influence over goals, rules, and everyday routines" of the organization. Ferris, Harrell-Cook and Dulebohn (2000; p.90) define politics as "organizationally non-sanctioned behaviour with underlying, but concealed, self-serving intent". The non-sanctioned behaviour, they say, consists of "competitive activities that threaten the interests of others, rather than collaborative activities that promote organizational unity" (Ferris et al., 2000; p.92). In a more benign form, they say, politics in organizations consists of self-presentation activities to convince others that the individual possesses characteristics and competencies valued by the organization. According to the above authors, the political actors conceal their true intentions and justify their behaviour in terms of acceptable motives. Some authors (Ferris et al., p.92) attribute the ubiquity of organizational politics across and throughout industries to an environment "rife with ambiguities due to rapid technological change".

Like the authors of organizational literature, nurses in the present study consider that "politics" has increased in the last five to ten years. While the former attribute the rise of politics to rapid technological change, the nurses correlate it with the changeover from head nurses to managers on the floor, and the attendant changes in the hospital organization. Nurses universally consider politics as a bad thing that adversely affects the interactive environment of the working group, and the well-being of individual nurses. The favouritism and apparent arbitrariness of the manager described by Emma

could have been seen as an effort to strengthen or defend a position of power, while the “bitching and complaining” of nurses on the floor can be seen as an effort by those complaining to exert sanctions (in the form of public censure) over nurses not conforming to the norms and rules of the working group. It is an effort to exercise influence over goals, rules, and everyday routines. It can at the same time function as a tension releasing mechanism: as Ranjit said, “it’s fun to complain” – to let off steam. Since the censured nurses are rather numerous, the “social influence behaviour” of those complaining is apparently not effective in changing the behaviour of the former. It does not have any identifiable outcome. When public censure is directed toward individual nurses, however, there is usually an outcome. The individual censured nurse either conforms to the norms of the working group, or she is banished from the group, permanently or temporarily, through the process of targeting.

Targeting and banishment is the extreme form of hospital politics. It is not, however, usually an outcome that the actors wished for, either explicitly or through “concealed intent”, as will be seen in the discussion of targeting in Chapter 8. Those taking part in targeting do not see themselves as perpetrators of targeting, but they do “justify their behaviour in terms of acceptable motives” (Ferris et al., 2000). The justifiable motive for targeting, as will be seen, is the desire to maintain standards of competency on the floor.

Targeting might also be seen as an exercise in boundary setting with regard to what is deviant and what is the group norm, as in Erikson’s classic study (1966) of the role of deviance in early Pilgrim communities. In the following chapter, the theme of competency and the construction of competence is examined more thoroughly.

## **Chapter 7: The Surveillance and Management of Competence**

"Am I competent enough? Why can't I get my work done in time?" [June]

### **Introduction**

Along with "politics", "competence" is another ubiquitous theme expressed by interviewees in the study. Their concern and anxieties about competence appear to have increased in response to the increased intensity of work, and other aspects of work that have changed during restructuring.

Beginning in the mid 1980's, articles in nursing journals throughout Canada and the U.S. have expressed concern about the possibility of encountering lack of competence on nursing floors (for example, Cerrato, 1988; fry, 1997; Miller, 1984; Muir, 1985; RNABC, 1980. 1984, 1987; Rozovsky, 1990). The issue of competence has become prominent in nursing discourse among nursing educators (Kelly-Thomas, 1998) and nursing theorists (Benner, 1984; Benner, Tanner, & Chesla, 1996). Nursing associations (Angus & Turbayne, 1995; Canadian Nurses Association, 1997; RNABC, 1996; 1998b) have drawn attention to the problem of ensuring competent nursing practice in a health care system that is undergoing rapid change. As the Registered Nurses' Association of British Columbia (RNABC, 1998a) points out:

Today's nurse must adapt quickly to a rapidly growing knowledge base, difficult workplace issues and fast-paced technological changes... Minimum practice hours are no longer sufficient by themselves to ensure competence to practice.

In response to the concern with the problem of ensuring competency, and following the lead of the Canadian Nurses' Association, the RNABC (1998b) announced a province-wide program of "Continuing Competence", and stated their intention to formalize criteria for ensuring and evaluating continued competency of practising nurses.

Nursing leaders have acknowledged the difficulties of operationalizing the concept of competence (Kane, 1992; RNABC, 1996), and numerous theorists have taken on the challenge. Benner (1984) and Benner, Tanner and Chelsea (1996), for example, conducted ethnographies in order to define nursing practice in terms of five levels of skill acquisition, and they identified "competence" as a level half way between beginner, novice, proficient, and expertise. In an ethnography of psychiatric nurses (Kunes-Connell, 1991; p.19) the author defines "competent" as "the evaluation of the self as capable of functioning on a task or interpersonal level", and she suggests that successful task-accomplishment and relationship capabilities in the work setting are related to "occupational self-esteem".

As a continuation of its Competency Project, and drawing from nursing theorists who had been conceptualizing competence since the 1990's and before, the RNABC (2004) has posted two recent publications on its website, and mailed out a booklet to its members titled "Standards for Registered Nursing Practice" (RNABC, 2003) that was included as an insert in an issue of Nursing B.C. The heading of one section of the booklet is "Competent Application of Knowledge" (RNABC, 2003, p.10), and includes a description of the nursing process (assessment, planning, intervention, and evaluation) as follows: "Makes decisions about actual or potential problems and strengths, plans and performs interventions, and evaluates outcome". Included in the "indicators" for this standard are aspects of the nursing process such as "collects information on client status from a variety of sources using assessment skills including observation, communication and physical assessment".

In "Entry Level Competencies" the RNABC (2004) lists "baseline expectations of

new registered nurse graduates". It describes standards such as the following:

"Collaborates with clients to perform holistic assessment of the following needs:

physical, emotional, psychological, cognitive, social, spiritual, developmental, cultural, informational and educational". The glossary of terms defines "competencies" as "The integrated knowledge, skills, attitude, judgment required to perform safely within the scope of an individual's nursing practice". "Skills" are defined as: "Activities or behaviors in the performance of tasks, carried out with a reasonably adequate degree of proficiency and dexterity. Skills can be psychomotor (including body movement and dexterity), cognitive (involving critical interpretation and decision-making) or relational (involving communication and being with clients)".

The above definitions of competence indicate the complexity of the entity of competence, and of its operationalization. Keeping in mind the comprehensiveness of the above definitions, and revisiting the discussion of routinization of work in Chapter 5, it becomes clear that the thinking involved in carrying out routines often falls far short of those definitions. The increased routinization of nursing work in hospitals, and the routinization in thinking that must accompany it, as well as other changes in the nursing labour process, may actually be undermining the aim of nursing leaders to ensure that competency in nursing practice is maintained.

### **Surveillance and the Fear of Incompetence**

"I felt not very competent at that point to make that kind of choice" [Louise]

Fear of being incompetent or of being thought of as incompetent permeates working life, beginning from the training period, and is particularly acute during the socialization period of the new nurse. This fear is found both in the new nurse herself, and among her colleagues. For instance Shauna, a targeted nurse whose case is



presented in Chapter 8, was very concerned and anxious that other staff might consider her to be "this incompetent nurse". I saw one nurse, a "junior" in a critical care unit, sobbing because she had entered an incorrect rate of infusion of Dopamine into a patient's IVAC, which was discovered and corrected by the nurse on the next shift to whom she had reported off. When I talked to her about it, she said that she was crying because of "the poor patient", and also because of what others would think of her now – she thought that it had ruined her image as a competent nurse both in her own eyes and in the eyes of others.

Other nurses said that concern about the competence of others working on the floor was important to them. In this respect, if another nurse made a mistake - even a minor one - that was pointed out to her, and she did not appear to take it seriously, this would raise doubts in the mind of others about her reliability. As Doreen said:

Even though it hasn't done any harm, it is an error and if you do an error with a simple thing it's always possible it's going to be serious some day, so you really have to take any error very seriously and really make note... You have to be really aware of everything all the time...if you sluff me off and it happens more than once then I don't get the feeling from you - you're saying it's not a big deal - then I would go to the unit manager.

On one floor a potentially serious mistake had been made concerning an insulin reaction: nurse M. who was covering for nurse B. on her lunch break had taken an "accucheck" to test a patient's blood sugar, but did not treat the low blood sugar. When nurse B. returned from her break and received the report of the low blood sugar, she rushed into the room, and finding the patient unconscious, called a "code". An IV was inserted immediately and a dextrose infusion was started. Another nurse on the floor (a union steward) said how acutely embarrassing it would have been for everyone on the floor if the patient with an insulin reaction were to "arrest" and die from it. That is, it

would have reflected on the whole floor as an instance of incompetence, since the patient could have easily been treated with oral dextrose while still conscious.

Helen, a critical care nurse who was often in charge for the shift had this to say:

And there's a couple that I don't think should be working there. I don't think they're competent. So I will not give them a really sick patient. The patients didn't used to be as sick, or we didn't save them. So perhaps in the old days, they were a bit keener, they had a higher energy level. But as they've got older they haven't got better. And the acuity has increased. Unless they actually kill somebody, you can document, document, and tell them they should look for another job, but I'm not exactly sure what you can do to get rid of somebody who's not competent. I wouldn't work with somebody like that, not on a full-time basis. And I mean, it's quite well known that they don't cope well.

Helen states that consensus has been reached concerning the two individual nurses she mentioned, although there are no examples of specific errors in judgment on the part of these nurses, nor to harm or death suffered by any patient. She has a subjective or perhaps intuitive feeling or perception that the nurses do not cope well or are incompetent, but it is never put to the test, because these nurses are never assigned challenging patients during the shifts in which she is in charge, and these nurses are invariably "bailed out" (other nurses take over), she states, when they encounter difficult or challenging situations. Helen searches for parallel (non life threatening) instances as evidence that supports her perception that a nurse in question is indeed, incompetent. She sets the stage by describing a very sick patient: "Like you think of the patient first...there was this septic patient on Levophed..." She goes on to say that when the resident doctor came to the patient's cubicle for rounds, the nurse caring for the patient started by giving a report about the patient's bowels. To Helen, it would have been much more appropriate for the nurse to begin the report by talking about the patient's vital signs, cardiac output, and urinary output. The other nurse's report was evidence that she was probably incompetent, and probably would not cope well in an emergency:

So I mean if you can't get your priorities right, then they're [the patient is] probably not going to get very good care. They could go on and on and on about something, well in the meantime the patient has crashed and burned. They [incompetent nurses] are not capable of prioritizing any more.

Helen voiced frustration that although some nurses were incompetent, it had not been possible to have them removed, even though she had compiled written evidence of their inferior performances and discussed it with others. She mentioned, however, that one nurse had been convinced to leave on her own. This had been due, she said, to the availability of other nursing jobs that had not been present previously:

But it took us a long time before she finally said yeah, it wasn't for her, so she did move on. But the others have not moved on. Well, there wasn't movement for a while, but there's movement now. So they should be looking elsewhere because they do not cope well with what they have. Well, you'd have to prove that [that they endangered life]. I mean they maybe haven't killed somebody, but someone else has taken over and done the work for them so they didn't.

Conditions outside the hospital impinge on what kind of nurses Helen finds herself working with. Another concern, she said, that was due to the fact that some hospitals are only hiring on a casual basis, many new nurses do not have in-depth knowledge and experience of any one nursing floor or unit:

We have some problems with newer staff we hired. They say they've had this much experience, but if they had that much experience at that many places sometimes that's not a good thing, because it means they've done 2 shifts here, two shifts there. You don't get really good if you're traveling around and around because usually they don't give you the really sick patients if they don't know you.

In this study, I did not talk with any critical care nurse who complained of seeing, or being the victim of targeting (with the exception of Kathy, the nurse who described a targeting incident in an ICU in the U.S.). It is significant, however, that of the 12 targeting episodes I was aware of, 10 took place on acute care floors, and none (except Kathy's) took place in critical care units. Based on my interviews and observations, it appears that had any nurse on an acute care floor been "documented" as Helen said

she was doing with the two nurses in question who worked in her ICU unit, the consequences would have been much more severe. One possible reason that no targeting incident materialized in the ICU could be the leadership style of the manager there. As Ranjit, who worked in the same ICU mentioned, the manager there did not encourage nurses to talk to her about other nurses, and was quoted as saying "Are you being fair?" when approached with complaints from one nurse about another.

Other reasons could include the generally higher self esteem that nurses in critical care appear to have, possibly due in part to the higher respect paid to them by other health professionals. As Ranjit pointed out, this respect is based at least in part on common language that nurses and doctors use in critical care. Critical care nurses are expected to give emphasis to things like cardiac outputs. Indeed, Helen may have experienced embarrassment when the other nurse did not report things in proper sequence to the doctor making his rounds. It would appear that most nurses in ICU's do not appear to have as precarious a sense of self-esteem as nurses working on the other two levels. Their self-esteem may also be buttressed or expressed through their many outside activities, enumerated by Ranjit. I noticed that nurses in ICU's and CCU's seemed calmer and more self confident than those working on acute care floors. Almost all have worked for some years on acute care levels before entering critical care. Moreover, as discussed previously, there is a finite repertoire of skills that they must use in this level of care.

There is more uniformity in the level of sickness among the patients in critical care, albeit more acute, compared to the patients in acute care, whose levels of sickness may vary dramatically one from another. The patients in acute care may

suddenly and unexpectedly require intense care that is not available to them on that floor, requiring sudden and hazardous transfer to the critical care level. On the critical care floor, on the other hand, everything is set up for quick and convenient responses to unpredictable events. This is one reason that nurses on acute care floors tend to be more anxious about competence than those on critical care floors.

Related to anxiety about competence is the constant presence of what I call "the invisible arm of the law". I remember from my own nursing student days, and observations since that time, that nurses are constantly reminded that they must document every aspect of care that is given, and that these records are "legal documents". Soon after I started nursing in 1984, the preoccupation with legality was corroborated among all nurses by the widely publicised case of Susan Nelles – a recently graduated nurse in the Hospital for Sick Children in Toronto who was accused of and eventually exonerated of killing baby patients with overdoses of Digoxin (Code, 1995).

Nurses working on acute care floors are respected and competence is inferred by other nurses on the floor when they appear confident and know where everything is at all times, and know all the protocols. Olivia, for example, projected competence, as she always knew where everything was, and other nurses got into the habit of asking her where things were, what form to use, or what protocol to use. This illustrates the importance of how the self is presented (Goffman, 1959) in the nursing workplace. Seminars and courses on how to present the self as competent and confident would perhaps be useful for students in nursing school, and for nurses transferring from extended care to acute care. On the other hand, the presentation of the self must be

managed skillfully enough to suggest confidence but not “overconfidence”. (As will be seen in the next chapter, her manager told Susan “other nurses think you are overconfident”). Cultural sensitivity courses could be offered, possibly under the broader topic of social constructionism, so that nurses may become aware of their own and others’ communicating styles.

### **Competency and the Socialization of New Nurses**

As Helen pointed out, new nurses working on a casual basis in many different places apparently do not get the consistent learning environment needed to become and feel competent. As Elaine pointed out, new nurses often do not receive the consistent support of more experienced staff who instead become annoyed at the extra work often caused by the inexperience of the new nurses, or their lack of conformation to the norms of the floor. They also lack educational resources:

I don't know what they're doing to help brand new grads learn quickly. The support's not in the hospital. The educator on our ward's never there, so our senior staff gripe and complain because the junior staff don't know how to do half the stuff they're supposed to do to do their jobs. So the senior staff ends up doing their job and somebody else's work. Or you end up coming on shift and find out someone else hasn't done something because they didn't know they were supposed to do it or didn't want to do it.

Elaine considered that new grads from university program had a more difficult time to socialize to the new floor than did those from a technical college:

because they didn't make as many connections on the ward. They didn't meet as many people during their multiple rotations, and [the technical college] did long rotations, so they spend a lot of time on the wards, and they were familiar faces.

Ranjit’s experience as a new grad at a small community hospital concurred with

Elaine’s opinion. Following is an excerpt from an interview with her:

Ranjit: What the manager had told me was that university nurses do not do very good at River Hospital. They just don't get along with the staff. “So you have to be very careful about how you behave” – that’s what she told me. So I’m like “Okay! I’ll do this job until I get another, then I’m out of here!” She also said we’re gong to be watching your behaviour. “We’re going to be

watching", she said.

A: Did you find that threatening?

R: Yes, but I had no other choice. That was the only job available.

A: Did you find that you were being watched? Were you ever aware of this?

R: I don't think I was – it made me feel – those statements made me feel very sort of paranoid for a while. I don't think I actually was that scrutinized. But those statements made me feel very paranoid for a long time afterwards. I hadn't been working for 8 months in nursing, so I had lost a lot of skills. I did have extended orientation, which was kind of nice of them. You were pretty much on your own. If you had an LPN that knew the ward, you did fine. You work as a team. So they knew what the habits were for that particular ward. Then it's easy – they sort of direct you – what needs to be done, and how and what. But if they didn't have a clue, then you were kind of lost... They keep cutting the education budget at [that hospital], so the education is not there to support the nurses either.

Ranjit had a self-confident demeanor, and in other parts of the interview as well, she demonstrated a high degree of insight into the dynamics of interaction on hospital floors. This may be why she did not experience the expected intense surveillance and was not aware of any consternation among the members of her new work group. She also received an orientation period of adequate length to give her the self-confidence she needed, even though the education budget of the hospital had been cut. She worked as a team with some experienced LPN's so that she was able to learn the routines and expectations of the floor from them, and gain confidence.

Shinder's experience at a small community hospital was not as positive, and she applied as soon as she could to a large teaching hospital:

I got hired at Western and didn't work as much at [a community hospital] as often because it's not fun there. I was casual, I was the lowest person on the totem pole and they only put me on the 24-hour notice. It's a terrible hospital if you're a new grad, especially from the University program, to start in. Because you have 3 RN's and 3LPN's who cannot answer any questions for you, and the other RN's are taking care of 12 to 16 patients. So they're too busy to answer any questions for you. So you're pretty much floundering. If you've got a question about how do you give Valium IV there's no one to ask, no one knows. They're just too busy, and they won't give you the time of day. They don't particularly like having university grads because they can't do nursing right away. Whereas if you got your education in a community college you have far more clinical

experience, and less community experience. The first 3 months the diploma nurses do a lot better, because they have far more hospital skills. After those 3 months there's no difference. But for the first 3 months if you're a university nurse you obviously suck at nursing. So I had to live with that for a while.

### **The Nurse Clinician – New On-Site Manager of Competency**

In the early 1990's, baccalaureate-prepared nurse clinicians were introduced to assist the managers with ensuring the ongoing education and competencies of the nurses on the floor, and at the present time are in the process of completely taking over this aspect of the managers' work. They are the new on-site managers of competence.

It is the responsibility of the nurse clinician to ensure that nursing standards on the floor are maintained. While some nurse clinicians are viewed as supportive, helpful, and friendly figures, others are viewed as vectors for hostile surveillance or even harassment. The following story illustrates the latter situation.

The nurse clinician chastised Asifa for preparing IV medication for a patient with a central venous catheter (CVC), when she was not certified to work with CVC's. After diluting the medication, Asifa went to the procedural manual to verify whether or not she was allowed to hang up the bag of medication, and found that she was not. She asked the charge nurse what she should do, and the latter said that she should ask the nurse clinician. Shara, the nurse clinician said, "You are not certified, you cannot give the medication". Moreover, nobody else could give it either, she said, since Asifa had already diluted it (and hypothetically could have diluted it incorrectly). On being asked to send up another bag of medication, the Pharmacy technician said that it was very expensive. Half an hour later, the manager called Asifa aside and asked her "How could you do this? You were giving an IV medication when you weren't certified". When Asifa came back from her days off, the manager informed her that Shara had reported the



incident “officially in writing”. She said that Asifa had “put the patient’s life in danger”.

She further told her “you have the art of nursing, but not the science part of nursing; you don’t have critical thinking”. She was told that Shara and another nurse would “be keeping an eye on me”; that she was being given a second chance and would not be given another chance; and that next time the union would be involved, and now Asifa must write a plan on how she would learn critical thinking. Asifa said in her interview:

This is the worst. This is the worst that can happen in my nursing life. I had never had such a terrible, horrible – like, you are terrified. You felt “Oh my god, you didn’t [do anything wrong] – you knew that no, you are good”. But it does affect your self-esteem. For one week I was really in a bad mood, I had anxiety; I was tense all the time.

At least two other nurses in the working group - Pat and Beth – gave Asifa support. Pat (while telling Asifa that “it’s all BS!”), assisted her to write “plans to learn critical thinking” while Beth organized supportive public opinion among other nurses on this and an adjoining ward, and interceded with the manager on her behalf. The incident, perceived as an incipient targeting episode, did not escalate to the point that other nurses were involved in it, nor did the manager end up asking her to leave, as happened to Shauna and Susan, discussed in the next chapter. Nevertheless, I noticed that months after this incident, Asifa (who had a gentle and sensitive demeanor) appeared distracted and to have lost confidence.

Real critical thinking (in the sense of analyzing a situation) was needed on the part of the manager and the nurse clinician in the above scenario, in order to bring about a needed or desired outcome. If the term “critical thinking” is applied without analysis of the situation, however, then it becomes merely a “buzzword”, rather than a concept to help grasp and resolve issues on the floor. Phrases used as buzzwords create what is perceived by front-line nurses as a new nursing rhetoric that have no

meaning for them in terms of the problems they face in their work. Phrases like “evidenced-based” and outcome evaluation” convey a sense of scientific thinking, and at the same time, a sense of acute business acumen. They are phrases that managers learn in contemporary management courses, as do baccalaureate nurses in more truncated versions of management courses. In directing Asifa to write out plans to achieve critical thinking, both the manager and the nurse clinician were publicly affirming their allegiance to the new paradigm, while making required motions to help a nurse become a better nurse. One questions, however, how much the exercise had to do with critical thinking, or with being competent. It appeared rather as the application by rote of a principle, phrase, or tactic, with little apparent thought or analysis of whether or not there was a good fit between tactic and concrete situation. The aim appeared not to be critical thinking, but that Asifa should know the rules and protocols of the hospital off by heart. Among other things, the incident illustrates that the avowed intention of maintaining nursing standards and ensuring competency by surveillance over some nurses, may instead stray into the realm of workplace bullying. The following story is an instance of just that.

### **Kathy's Story**

Kathy is a critical care nurse originally from the U.S. Her story takes place in an ICU in a city in the U.S., and she told it to me in the context of my questions to her about “politics”.

I was the victim of it for a while...this charge nurse decides she didn't like me. So she got her little team out, and she called them in her office, secretly of course, and said, “I want you to look for anything you find on Kathy. And I want you to write it down. Anything bad at all. I want it. Submit it to me in writing. And I want you to look for it til you find something”. This was all unbeknownst to me. And I'm just feeling this tension all around. I found this out from these people after on. The more tension I felt, the more inadequate I

felt. I could just feel eyes all over me, and I was just scared to do anything, because I knew if I made one little mistake, I was going to be history. And that was so much pressure for me. I was just a basket case. And the thing is, when I feel supported and appreciated, man! Don't I work hard! I will give you 150%. But the feeling, that sense of not anyone understanding that I was a good nurse, I was competent. Because they didn't know that, and I had to prove myself. It wasn't even just prove myself. They were looking for bad things. And you know that whatever you're looking for, you're going to find.

With the assistance of a supportive clinical nurse specialist (a nurse prepared at the Master's level), Kathy worked out a plan and eventually gained respect, acceptance, and support of most of her colleagues. This lasted until a new department head arrived.

Then they got a new department head, and things changed and then before you knew it, like right at the end of my being there, it was happening again. Because the main vultures were still there. And they kind of liked that little role they had. It gave them power. They felt powerful. They liked to scrunch on their young and eat them. I see a little bit of that in this unit [in a hospital in the Lower Mainland]. When I first came here, people would say "There's a group of people that are on a power trip, and if you get in with the group, you're all set, and if you don't, forget it, they'll make your life miserable". Well, I immediately recognized who the people were, just by observing, you can tell. I could recognize them just by their attitudes, there's just the way they walked around like "this is my unit" and they're the ones in the cafeteria talking about everybody else, putting them down.

About nurses who were targeted, Kathy said:

It was always people that wanted to please so much. So, in that wanting to please people there's a little bit of fragility. You need that to be able to feel good about yourself. I noticed that when people came in and they were really confident - you know they could be lousy nurses, who knows, but they just had this air of confidence, they thought they were pretty good. They never got picked on. It was the ones that were really sweet and just wanted to be helpful, and they were just so vulnerable. People would pick up on that vulnerability. Now you have to understand that I'm a little tainted right now. I have strong, strong feelings about all of these issues because I have been through them and my life was hell for a while. It was hell. I just thought, "This is so unnecessary. This job is so stressful as it is". We expose ourselves as nurses to a lot of things, and why should they have to put up with abuse from their peers?

In light of the above stories, the three studies on targeting identified in the literature review in the first chapter are now synthesized to present a typical or composite picture of a targeting episode on a hospital floor. This will be compared and contrasted with the description of actual targeting episodes presented in Chapter 8.

### **Synthesis of Three Studies on Targeting**

The "singling out and targeting" process described in qualitative studies of racism in nursing by Calliste (1996) and Das Gupta (1996), and the exclusionary process described by Lemert (1962) appear to be the same phenomena. In this section, elements from all three studies are synthesized to present a plausible picture of how exclusionary interaction on the hospital floor might look. In this synthesis, elements of other related studies are included.

Lemert states that there is interplay between the "differential reactions" [increasingly disparate understandings] of both the targeted person and the "others" in the group, the actions on one side potentiating the reactions of the other to the point where there is a complete disruption of usual communication and a crisis in the organization. The crisis is resolved by the physical removal of the targeted person; in the case of a hospital ward, the targeted nurse is removed through suspension or termination (Calliste, Das Gupta), or she may be advised by her union to take a holiday or a stress leave.

Lemert states that the exclusionary process begins with persistent interpersonal difficulties between the individual and his/her work associates, which the associates at first interpret as a variation of normal behaviour, until a perceptual reorientation takes place, whereupon interaction changes qualitatively. On the nursing ward, the generic period of the exclusionary process begins with close surveillance of a nurse because she is different from the norm in some way: she may be black (Calliste, 1996; Das Gupta, 1996), or "peculiar" (Smith, 1990a), have newcomer status (Kramer, 1996), or be stigmatised from having worked in a less prestigious area of the hospital - for

example, a nurse moving from an extended care unit to an acute care ward.

As described by Calliste and Das Gupta, the manager begins to document mistakes of the targeted nurse that have been reported to her or solicited by her from work associates of the nurse. These mistakes may include using the hospital phone for personal calls, talking in a louder than normal voice, not checking a label, missing a medication order that has been written in the patient's chart by the doctor. Each time the manager receives a report of a mistake or oversight, she takes the offending nurse aside or calls her into her office (this act is witnessed by the other nurses on the ward) where she is told about the mistake. Since most of the mistakes are minor to begin with, and would be overlooked if committed by other work associates, the targeted nurse may feel that she is being unfairly singled out and harassed (Calliste, 1996; Das Gupta, 1996). This is the point in the process where a perceptual reorientation and qualitative change in interaction may take place (Lemert, 1962).

Up to that point, other nurses at the workplace may see that the nurse is going through a bit of a hard time, and may even be sympathetic (as in Smith's account, 1990a); they are still willing to make allowances as they do not yet see her behaviour as abnormal (or, as Smith suggests, they may be preparing the ground so that their later actions can be seen as fair and reasonable). If the targeted nurse becomes rattled, however, and begins to express hostility, fear, or worse yet, begins to make mistakes that matter, such as "medication errors", the process has moved into the production of incompetence and exclusion. As noted by Calliste and Das Gupta, the manager now begins to actively solicit reports about the targeted nurse in full view of her colleagues; the manager may even phone nurses at home to get information about the incompetent

nurse, which she compiles in a folder in her office. The nurse's incompetence may be "announced" by other means as well: for example, the status of "Charge Nurse" for the shift may be awarded to another, more junior nurse, and ostentatiously posted on the nursing station blackboard for all to see (Das Gupta, 1996).

Lemert describes the ensuing interaction between the targeted person and his/her co-workers, and the beginning of the disruption in communication between him/her and the co-workers, thus: "conversation is evasive..the individual is met with under-reaction or silence" (1962; p.9). Co-workers avert their eyes from the incompetent nurse, but conversation in front of her is contrived to appear as if everything is normal. A coalition among the workgroup may appear demanding loyalty, solidarity, and secrecy from its members (Lemert, 1962), with a common commitment to depose the incompetent nurse. Communication among members of the coalition becomes intense, but is disguised or hidden from the excluded member. Members of this coalition appear unnaturally cheerful when interacting with the targeted nurse, while those who are not members of the coalition, especially those who were friendly and sympathetic at the beginning, appear troubled and downcast. As the interviewee in the Calliste (1996; p 371) study remarked "camps seem to form on a unit. You have the nurses that are pro and con for one particular nurse who is singled out."

An organizational crisis develops on the floor/unit. Even among members of the coalition who are demanding that something be done about the incompetent nurse, there are "intolerable anxieties". Lemert states, "the individual may act in ways which arouse intolerable anxieties in others" (1962; p.9). These anxieties, he thinks, arise from fears about organizational vulnerability, and anticipation of retaliation from the

paranoid person. The imputed dangerousness of the individual, which becomes magnified, also lays "a functional basis for conspiracy" and a justification for collective action to contain or oust him/her. Yet the anxiety is not merely tactical, Lemert points out: the fears of the participants, he states are quite analogous to those of classic conspirators. An interviewee in Lemert's study, a leader of such a conspiratorial coalition, stated that he felt a week of terror, stomach upsets, and insomnia. This correlates with an episode in the following chapter (the case of Susan), where the manager involved in a targeting episode felt adverse health effects and had to "hibernate in her room for a weekend".

In these three studies which have been synthesized, the outcome is the same: the targeted individual is cast out from the group by means of firing, suspension, or "moving upstairs", sometimes followed by (in Lemert's study) the eventual commitment to a psychiatric institution. As evidenced in the studies by Calliste and Das Gupta, there are other nurses committing minor infractions, such as being late or using the hospital phone, who do not become targeted nor progress to the stage of "incompetence". What factors are operative in selecting which nurses travel along a continuum leading to eventual exclusion, while others do not? Are there success stories in which nurses prevent the exclusionary process from culminating? It will be seen in the next chapter that some conditions provide a ready incubating environment for targeting episodes to develop, while others do not; and as was seen in the stories by Asifa and Kathy, targeting episodes can be circumvented or aborted by timely interventions of other nurses. Different management styles are also implicated in whether a targeting episode culminates in an exclusionary act or not.

The targeting episode, while it divides nurses pro and con the targeted nurse, according to Calliste, demoralizes nursing staff and makes them afraid. The targeted nurse serves as an example of what might happen to those who step out of line. It also appears to serve to unify nurses. On one floor where I did participative observation, it appeared that nurses were united in condemning one nurse, Kay. According to Caitlin "[She] is incompetent. She does not uphold nursing standards. If she worked day shift she would not last, she would be fired". On questioning, I could not get any statements that would illustrate incompetence. This was similar to the interview with Helen, who had difficulty identifying what made two of her colleagues incompetent. When asked, Caitlin would appear to search her mind, and then hesitatingly offer stories like the following: "A patient said he had a very sore throat. Kay said it is from the ET tube and did nothing. She should have done something, like get a glass of water, a throat lozenge, or something". This incompetent nurse seems to provide a standard against which the rest of the nursing staff may compare and assure themselves that they are competent and are upholding nursing standards: that is, she illustrates "this is what competence is not". (This, again, brings to mind the role of deviance for Erikson, 1966). Also, it appears that she provides a common focus for their discontent and unhappiness - something tangible to complain about. As Ranjit observed:

Sometimes, when you start to complain it's fun complaining. And it just gets – on and on and on. And they start making stuff up that just doesn't fit the picture anymore. Like the person might have had a bad day and they're a little gruff sometimes. And they'll take that on to mean "Oh they don't care about nursing" or "They're horrible nurses". They extrapolate things that just don't exist, because it was fun to complain. That's what I think happens a lot of times.

She added that such complaining is more likely to happen when people are tired and overworked: "I think any place where the staff is overworked, there is a higher incidence



of it happening. Because the staff are already tired, and it's easier to bitch about things when you're tired".

Ranjit gave her views on how such episodes can be prevented from happening:

The best way [to circumvent this] is to have a good manager who doesn't stand for that. Like Barbara in the ICU – people start to complain, "Oh we don't like this person because they did this" and she'll say "Hold on a second, are you being fair? Is this why you think this, or is that why you think this?" She makes you think those things through, so she really prevents a lot of those things from escalating. And if you have a good manager who catches those things, and you have good role models, that are respected role models, that prevents those things from escalating.

Ranjit is saying that there may be a legitimate criticism to begin with, that may be reinforced by things that are "made up", as the complaining begins to take on a life of its own and escalate toward a targeting episode. The participants of the targeting-episode-in-process extrapolate the original complaint to an imagined "horrible" extreme, so that the targeted nurse becomes a "horrible nurse". The escalation of a complaint from criticism to a targeting episode is more likely, Ranjit thinks, when nurses are overworked and tired, when there are no respected role models among members of the working group, or where there is a manager who does not take a firm stand against such escalation. The person targeted, she thinks, is usually shy, or is in some way different, or "does not fit into the group yet". In the following chapter, two case studies of targeted nurses are presented.

## Chapter 8: The Construction of "Incompetence"

### Introduction

During my fieldwork, I witnessed or heard of 12 instances of interaction that could be construed as targeting. I was aware of one nurse "disappearing" during my fieldwork: I asked what had happened to Kay, about whom I had heard two nurses on one ward talking in an angry and disparaging manner two weeks previously. Another nurse replied, "She has disappeared off the face of the earth!"

In addition to the above case, I became aware of 11 more instances of targeting. Three of the targeted nurses were of Black Caribbean origin (Shauna, Rose, and Winnie); two were Philippina (Philomina and Marilla); one was of Middle Eastern origin (Asifa); six were of Anglo/European origin (Susan, Iris, Kathy, Jill, Bess, and Kay). In addition, there was one possible case of targeting - a nurse of East Asian origin (Mary). I interviewed five nurses in depth about their experiences of being targeted and one talked to me briefly about it. The other six of whom I was aware I could not contact, or they chose not to talk to me about it. I interviewed another nurse in depth who had been involved in initiating a targeting episode, and interviewed many who had witnessed targeting episodes.

Of the five whom I interviewed in depth, I chose to present two case studies in this chapter. One reason for choosing these two nurses as case studies was the large amount of data available in both cases. Another reason was demographic: one nurse is of Black Caribbean origin, while the other is of white British origin. I wanted to illustrate that while targeting may be more likely directed to nurses of colour, as Das Gupta and

Calliste maintain, it is not restricted to those nurses. I considered that presenting a case study of a nurse of Anglo European origin might help to more fully reveal the phenomenon under investigation.

I have chosen to use the term "targeting" rather than "mobbing", since it usually involves only one or several other nurses on the floor actively participating besides the victim or targeted person. The term targeting is also preferable to "bullying" which implies malice and intent to harm. None of these above terms, however, is sufficient to explain the full extent of the interaction, which I term "anxious competence" and "projection of incompetence in the other". This will be explained more fully at the end of the chapter.

While I interviewed five nurses in depth about their experiences of having "difficulties" on the floor, the story of one of them, Iris, I did not consider similar to the other cases of targeting. Iris (a nurse of European origin in her mid-fifties) described feelings of distress and shed tears as she described how the atmosphere of her extended care floor had changed since the previous manager, who was well liked, had been fired, and a new manager had taken charge. Iris said that she and a group of other nurses from the floor had complained to the upper management and the human rights department about the new manager soon after she arrived. According to Iris, the new manager carried a grudge about the incident, and "picked on" Iris and some other nurses continually. Iris considered changing floors, but decided against it, because she had grown attached to the patient/residents there, and she did not want the manager to get the better of her. This manager, incidentally, was the only manager who refused my request to do participant observation on her floor. The situation Iris described might well

be termed “workplace bullying” or targeting, but it was different from what I was observing in the other four cases. The story of Kathy (in the previous chapter) I also came to consider as a case of bullying, apparently emanating from the manager, rather than as an example of the phenomenon in which I had become interested – that is the phenomenon of “anxious competence” and “projection of incompetence in the other”. From the remaining interviews, I chose two narratives as case studies in the kind of targeting I call “anxious competence” or “projection of incompetence in the other”. The first is Shauna - a young, black, newly graduated nurse who had worked briefly on an extended care floor, and then got a position on an acute care floor in the same hospital. She had emigrated with her parents from the Caribbean to Canada while a small child. The second case is Susan – a forty-year-old nurse of British origin, who had also transferred to an acute care floor from an extended care floor, but who had previous experience on an acute care floor. Asifa, the other nurse who was having difficulties, was Middle Eastern in origin. Though she felt distress at the episode, it did not escalate to a full-blown exclusionary act, due to the interventions of some of her colleagues. She survived the episode without having to take official time out, though she did take some days off “sick”. It is interesting to note that she also had transferred recently from an extended care floor.

The narratives of Shauna and Susan are presented as case studies. Extensive excerpts from transcribed taped and hand-recorded interviews are included in this chapter. The narratives are remarkable in their similarities to the composite picture of targeting composed from the descriptions of Lemert, Das Gupta, and Calliste - described in the previous chapter. They also contain, however, significant departures

from these earlier studies, which are discussed at the end of this chapter.

### **The Case of Shauna**

Near the beginning of my participant observation on this floor (which I call "A" Ward), I first noticed Shauna as a new nurse standing back slightly from the area where people look at the assignment sheet, observing everything intently, but not taking part in the back and forth easy chit-chat of nurses coming on and off shift - the ease of their bearing identifying them as established nurses on the floor. This new nurse was young, black, and a nurse told me she had just come from extended care to a part-time position on the ward.

About a month later, near the end of my stint on this ward, one of the nurses (Rita) said, looking at the rotation sheet said, "Shauna and Mary are gone". "How come?" I asked. "They've been fired, I guess", she answered. I looked at the rotation, and saw that those names were crossed off. Mary was a nurse who had been on the ward for about a year. A nurse had told me about a week earlier that Mary had made some serious mistakes with regard to not treating a patient who had a dangerously low blood sugar, so that the patient became unconscious and had to be revived with IV dextrose. I also heard that she had overdosed a patient on Demerol, so that he had almost stopped breathing and had to be revived with Narcan. No one had told me anything, however, about Shauna.

I asked Rita to look up the phone numbers of both nurses on the ward telephone list, and leave messages on the voice mail of each nurse on my behalf, asking if I could talk to her. Mary did not reply to the message, but Shauna did. When I asked her over the telephone what had happened, she replied that her manager had accused her of

overdosing a patient with a narcotic, and was demanding her resignation. I immediately said "Oh, no, she's got you mixed up with another nurse". I advised her to get in contact with a union steward. I later interviewed Shauna for about 2 hours in my home. She said she was happy to tell her story, because nobody else had asked her what had happened, or discussed it with her, so that she perceived there was "a silence, like a code of silence" and it was "like I never existed". She wanted to set out the facts, so that other nurses would not think of her as "an incompetent nurse". She also said "I could be paranoid, but I think I see people looking at me, or you know, looking at me differently. I just feel tension there".

One day, Shauna said, the manager unexpectedly called her into her office along with the nurse clinician, and to her complete and shocked surprise, demanded her resignation, on the basis that some nurses had reported to her that Shauna had overdosed a patient on Demerol. Shauna did not know whether to believe that the wrongful allegation by the manager was done deliberately or in error: (Note: It is odd that a manager would make such an allegation without the documentation in front of her, such as patient chart, record of medications given, with RN signatures). She said:

[disbelievingly] You have to explain this to me. If you or somebody calls the manager and says, "This nurse overdosed a patient on a narcotic, and didn't know how to give Narcan, and the patient had a central line" – wouldn't you think that the person would leave the name of the nurse with the manager, and the name of the patient? So how is it that that mix-up came up, and [the manager] accusing me? I don't want to look for the worst in people, I thought that she genuinely - "No, my manager can't do that", she can't accuse me and there's somebody else. She can't knowingly know it's not me, it's you, and say it's me. I said "Okay, it's a mix-up"

She concluded that the manager had not consciously made the wrongful allegation, but that the manager "was trying to make a case for herself":

I think she was trying to make a case for herself. And she tried to use the things that she had, and she tried to add more to it. And I don't know, maybe subjectively or something,

probably in her head, she probably didn't do it consciously, but she just felt that "Shauna's been doing that, it must be Shauna". Not intentionally.

After the manager called Shauna into her office that day to ask for her resignation, she told Shauna that she was an incompetent nurse and threatened that if she did not resign voluntarily, then she [the manager] would "make life hell" for her and fire her.

She said that I was not suitable to be a nurse, and she doesn't know how I made it through nursing school. And that basically, I meet the very minimum basic requirement of a graduate nurse. "*Minimum*", something like "worse than fail", the way she's saying it. Basically she trashed me, she said, "You're incompetent". She said that if I try to stay and do not hand in my resignation, she's going to make my life hell, she promised me that she would make other nurses watch me and follow me and she guaranteed that I would make more mistakes than I ever made. She even gave me an example, too, to top it off. She told me that last year there was a new grad from [a community college] who made a lot of mistakes, and they wanted her to resign and she made other nurses and the nurse clinician watch her, and follow her, and she said "That nurse made more mistakes than she ever made in her life, because naturally, Shauna, if somebody's following you and watching you, you're going to be more nervous. So I fired her. And I tell you, Shauna, if you stay, this is what is going to happen to you. I'm going to make other nurses watch you, I'm going to make Sheri [the nurse clinician] follow you around for three days, and I promise you, you will make mistakes and I will fire you. I will do a big write-up in your file about all the mistakes you made, and as a new person who just graduated [in imitation of the manager, Shauna's voice changes to a soft sweet voice indicating concern for Shauna] you don't need this at all, Shauna. You should just leave gracefully, you're a new grad, you can start your career, and you can start afresh. If you leave now, I will put nothing in your file, it's just between you and I. I will erase all that. I will say that you left because it is too far to travel, or something, or you can put whatever you like. Just resign.

Shauna, though taken by surprise and shocked, was able to think immediately of a tactic to give herself more time:

I told her I would let her know in a week's time...because I don't like to make decisions hastily. I like to reflect and think about my options. I phoned a week later and said "I haven't made a decision yet". She said "What!?" [sharp voice]. She said "If I don't get your resignation letter by 3:00 pm today, I am going to resign for you. I am going to fill out the form, and put what I want there." "Okay," I said, "you do what you want, but I'm not ready yet". [She] said, "You have no choice. It's not up to you, it's up to me" and don't even show my face at the hospital anymore, or words to that effect.

Shauna called a union steward who expressed outrage to the manager about her breach of the collective agreement, in that the manager had called in a union member

for discipline without having a steward present. The union demanded that the manager should make a verbal apology to Shauna for mistakenly accusing her of overdosing a patient. According to the collective agreement, the manager did have the right to ask Shauna to leave the ward (but she did not have the right to tell her to resign), since she was still within the 3-month probationary period, whereupon she could have gone back to the ECU floor. Instead, a compromise was worked out between the manager and the union whereby Shauna was moved to an adjoining less acute ward [the "B" ward] where the (same) manager would put a plan in place to "meet Shauna's learning needs". Shauna, agreed to the compromise:

"She thinks I'm incompetent? So make me competent". I didn't believe that. I went along with it because she's the manager, I want a job, and I want to clear my name. I want to prove to her and to myself, and of course I'm gaining the experience, and the knowledge and the teaching and everything that comes with it. I could have just left. But I challenged myself. "It will be hard", I said to myself, "but coming out of this, I'll be a better nurse in terms of skills, and everything". I said to myself "I'll be the winner in the end".

As Shauna began to try to make sense of what had happened, she thought back to her initial interview with the manager before being hired to work on "A" floor. She had let the manager know that she thought she would learn a lot on the new floor, but that she would need support to become proficient in certain skills.

I knew it was going to be a transition. As a new grad there's a lot you need to learn about organization, and I think the ward had a lot to offer me, and I had a lot to learn there. I don't really understand how the whole thing came about. I mean, I know my limitations. I understand that it was going to be hard. Because when I did my interview with the manager, I said to her "You know, I'm concerned, there's things I have to work on, I'm kind of nervous about going into this field." She said, "Oh you'll be fine, don't worry".

The manager appeared to have assured Shauna that she would get the help and support she needed. When she began her first shifts on A floor, one of the first questions the members of the working group asked her was where she had worked before:



But of course when you get onto a new ward everybody asks you "Where were you working before?" [I answered] "I've just graduated, my first job was in extended care" I didn't know – nothing wrong with that.

She described how she felt a lack of acceptance by some members of the working group, limited support, and a frustrating sense of isolation:

There were situations like I felt like – with a few nurses who were so cool. Few were supportive to a new grad, I felt like sort of isolated. I don't know if it was, whether it was because I was a new grad or because I came from extended care, or I don't know what it was. I would say a lot of the nurses were very helpful and supportive and stuff like that, but I felt like – I tried, I had to try very hard to fit in. the only thing is if you make a mistake, then they notice you, but otherwise they don't notice, like hey! Can I help you? Are you OK? None of that. And I always felt I had to push my way. I find there's already groups – that's what I noticed. Like certain nurses stick together, they hang on together, they party together, they do things together, and they help each other. And for me, I felt like an outsider. I tried to do things to just to fit in, laugh when they laugh, put in my two cents worth when they're talking, but I never fit in. So I thought, okay, it's going to come with time, right? You know, I don't like to use the excuse that I'm black, but I think that could have been partially the reason, because I was the only black nurse on the floor.

Even nurses whom Shauna perceived as friendly were either not aware that she needed more help, or were not willing to divert time from their tasks to lend her the needed support:

I mean the nurses there, there's nice ones, but they're very – they're so much into the task, that they forget this is nursing, that we're nurses, and that we need to care, and not just care for the patient, care for each other, care for ourselves. And there's nothing like that – they're so task oriented. Tasks, that's it. They forget there's people around.

Shauna had been prepared to learn and practice new skills on the ward, but found that the learning environment that she needed in order to master these skills was not there. Since she wanted very much to learn how to nurse at an acute level of care, however, she persevered, despite feelings of distress:

After work I was like very stressed out everyday when I go home. Not so much because of the work, so much, it's just – I mean if you are going to hire new grads then I feel you have to have a supportive environment, because I didn't do a preceptor there, I'd been thrown in. I have some knowledge base, I have this [high] GPA, but you know I felt like I wasn't ready in terms of the skills, I just needed to practice them, and – I felt that the support wasn't there for me. I did ask for help when I needed help, right? But I felt like sometime when I ask for help – [it wasn't there because] it was so busy, when I asked questions, people were busy doing their own thing. And I was told from the beginning,

even if I want more orientation time – two days and two nights, that's it, there's no more. So if you can't get your act together by then, basically, you're out. I felt like it wasn't enough, but I wanted the job, so I didn't say anything.

Shauna's experience contrasted sharply with another new grad, Nancy (a nurse of Anglo origin), who had preceptored there. During her preceptorship, Nancy was "taken under the wing" of the nurse she was matched with (a nurse who was well established in the "in" group), who was responsible for teaching her. This new grad was given affectionate nicknames such as "little buckeroonie" by the preceptor, and by dint of association with the well-respected nurse, was accepted into the "in" group. She made minor mistakes, as did Shauna, while continuing to learn on the job, but these did not receive the censure that Shauna's (also minor) mistakes did.

Shauna went on to describe some rude behaviour from a nurse (Tara) who was one of the small numbers of nurses who always "gave the cold shoulder" to Shauna. One night Tara "grabbed" the oxymeter from Shauna who was about to use it, saying she had a sick patient. Shauna asked her if she would return it after she was finished with it. Tara came back and "threw the oxymeter" at Shauna, later apologizing for her behaviour. One day I had observed this same nurse question Shauna who had "taken report" for Tara's patient who was about to arrive from the ER. Tara asked, "Did they say he is on telemetry"? Shauna replied, "No, they didn't". Tara then phoned ER to get the report again first hand from the ER nurse, thus demonstrating to everybody in the nursing station within hearing that she did not have confidence in Shauna's ability to take a report accurately. Tara was of Iranian origin. When I did participant observation one night shift, I found her to be vivacious and at ease during night shift but I observed her to become watchful and tense when the day shift arrived and nurses from both

shifts began exchanging "chit chat" with each other and going over report. I also observed that she was very tense when a patient appeared to become sicker. Tara had said that it took a long time for her to get a "line" on this ward, and she thought that the manager was biased against her. Shauna said about Tara's rudeness: "Of course I ignored her, because I'm new to the floor, I don't want to make enemies, and don't want to cause a problem, so I was just swallowing it, you know. I'm very assertive normally". Shauna was aware that Tara "hung out" with Elsie, a member of the "in-group" who Shauna felt was watching her (in the sense of surveillance).

It is significant that both Tara and Shauna are members of racialized ethnic groups but nonetheless one was causing difficulties for the other. In addition, Shauna suspected Rita (who was Philippina) of "ratting" on her. Harkening back to the interview with Asifa, it will be remembered that the nurse clinician whom she perceived was harassing her, was also of non-Anglo European origin. Shauna said that the manager who made life so miserable for her was "Oriental", and therefore had to try extra hard to climb the ladder of the hierarchy. These examples warn against a simplistic and uncritical use of the conceptual triad of "race, class, and gender" as an analytical tool. They also illustrate that one prong of the triad cannot be considered without considering the other two: in this case, it is very instructive to consider the factor of class in addition to the attributes of racialized ethnicity and gender.

The concept of "oppressed group behaviour" could also be instructive in considering the oppression of a member of one minority group by the member of another minority group. Tara, for example, felt somewhat marginalized. Although she "hung out" with a member of the in-group (whose members were all of Anglo-European

origin) she appeared not to feel very secure. She therefore may have projected her feelings of being marginalized onto Shauna, marginalizing the latter. Likewise, the manager who was East Asian seemed to “pick on” nurses who were members of racialized ethnic groups more than those of Anglo-European origin – for example, by phoning them at home when they took days off sick to check that they were really sick. One extended care nurse said that her manager, who was of East Asian descent, favoured hiring nurse who were also of East Asian descent. May, also a nurse of East Asian descent said, “Yes, she hires us, but she hates us”. According to the framework of Franz Fanon (cited by the critical theorists Hedin, 1986, Roberts, 1983, and Thompson, 1987) this statement could illustrate that the manager had internalised disrespect shown to her by members of a dominant group, which she then projected onto another even more vulnerable member of the same racialized group. It is not possible in the present study, however, to verify this.

Since Shauna found that her best efforts to fit in and find the support she needed from members of the group went unrewarded and unfulfilled, she decided to withdraw emotionally from them, and cope on her own as best she could. This, however, was a catch-22, because the members of the group then faulted her for not asking them questions, as would normally be expected from a new grad. They did not feel assured that she was performing her tasks competently, and they communicated to the manager and among themselves their lack of confidence in Shauna as a team player. Shauna became aware that she was “being watched” – not in a friendly supportive manner, she perceived, but in a threatening manner:

Having people rude to me, and people watching me, I just wanted to stay away from everybody – so I guess I went on my own. I went on my own. I said to myself, “Okay, you

guys are on your own". I still tried very hard to fit in, but I guess I went and did my own thing. I'm a nurse, focus on my patient, I came here to do a job, I'm going to do a job, forget about you guys. That was my mentality then, right? Because I don't need this. So when I did that [going off on her own] they complained to the manager that I don't ask for help. They don't have confidence in me, because I'm new and I don't ask for their help and I'm always on my own. Well, I asked for help, and they're too busy, and when I tried to get in they're rude to me, and they're not confident in my skills because I have to prove myself to them. They felt like I'm not a team player. I wanted to be a team player, but the team's already formed. And this other nurse, she always hangs out with Tara, she's always following me, watching everything that I do. I mean I can be doing vital signs, and who's standing there? [Elsie]. I mean, come on. It's not just in my head. She's just there watching me.

Similar to the subjects in Kramer's study (2000), Shauna was feeling "a heightened sense of self-consciousness", as she became aware of intense evaluative and hostile scrutiny. At stake was the all-important identity of "competent nurse" - so crucial for self-esteem, respect from self and others, and acceptance on a nursing floor.

When I interviewed the manager approximately one month later, she alluded to one of the complaints that nurses on the floor had made about Shauna:

For instance she didn't know how to give blood, and instead of asking someone to show her - everyone was busy - she decided to leave it until the next shift. By the time the second unit was ready, the cross match had expired.

It appears in the above excerpt that the doctor had previously ordered Shauna's patient to be cross matched for a possible blood transfusion, and then ordered the blood to be given two days or so later. The laboratory/blood bank would have phoned to the floor to announce that the first unit was ready to be picked up. Everyone was busy, and it was near the end of the shift. A more seasoned nurse might have gotten the unit of blood delivered to the floor, and started the transfusion as a favour to the nurse on the next shift, or to avoid censure. Presiding over a blood transfusion, for a new nurse, is rather intimidating. She will have learned during training that patients having a transfusion may suddenly have a potentially life-threatening reaction to it. Hospital protocol requires that

when a unit of blood is delivered to the floor, the nurse must get another nurse to check it over carefully with her, and then go with her to the patient's bedside to check it again. She must take the patient's vital signs. Once the transfusion has been started (and it must be started within one-half hour after arriving on the floor), she must take another set of vital signs 10 minutes later to ensure that there is no reaction. Shauna must have wondered if she would be able to get another nurse to check the blood with her, since everyone was busy. She may have wanted assurance of the proper protocol for hanging it. She decided to leave it for the next shift. This decision was a sound one in terms of patient safety. It is not a good idea to start transfusing a patient near shift change, since they may go unmonitored for some time until the nurse on the next shift finishes getting report. Shauna erred on the side of caution. For the nurse on the next shift, however, it meant that she had to hurry through report in order to get the blood up in time. By the time the first unit "had gone through" however, it was too late to call for the next one, because the cross match had expired – the blood test would have had to be done again. The annoyance and stress experienced by the nurse on the next shift was evidently conveyed to those on the previous shift. For the manager, it meant a waste of resources, in addition to dissatisfaction among members of the nursing group.

Shauna identified another nurse who had been very "cool" to her, or rather had ignored her and not said a word to her during the whole 12 hours they worked on the same shift. I remembered this nurse as very nice and friendly to me. She had been pregnant, and had some complications during her pregnancy. Shauna also identified two nurses whom she considered had been helpful and friendly to her, and called them "model nurses" – Laura and Mona. She did not remember the names of any other

nurses on the ward.

Things went on like this until the day the manager called her into the office, and in front of the nurse clinician, accused her of overdosing a patient with a narcotic, and demanded her resignation. In the adjoining "B" ward to which Shauna was moved, the manager followed through on her promise to "make life hell" for her. According to Shauna, she instructed the nurse clinician to follow Shauna around, and she asked other nurses on the ward to "watch" her. Shauna could see her "pulling nurses aside" and talking about her. She was called in to the office frequently for meetings with the manager and/or the nurse clinician, often in the middle of her work, and in front of others. She had to submit "learning plans" every month to the manager and nurse clinician, as though she were still a student. To add to her humiliation, she had to troop past the "A" ward in view of everybody there to go to these "meetings". She said, "In front of the nursing station she will come and say, "Shauna, I want to talk to you". In front of all the nurses, and they see me walking behind her to her office".

These symbolic demonstrations of Shauna's unreliability and inferiority affected how other nurses on floor "B" saw her:

I feel that some of the nurses on the floor don't respect me because of the whole thing. They talk down to me..tell me what to do – bring this, bring that, do this, do that....intercede when I'm talking to a patient. They treat me like I don't know anything. I still have to submit "learning plans" every month, and look at videos about palliative care, dementia. And there's a new nurse there hired last week – she did her preceptorship there – they talk to her like a full-fledged RN, like she knows. A nurse will say to her [the newly hired nurse] "I don't want to undermine you, I just want to point out.." and the girl will say "Oh thank you I appreciate it". But not me: do this, do that, I feel like my ability there is undermined, and I feel that they think that since I was under scrutiny, and since [the manager] probably asked everybody there to watch me, they don't trust me. They don't trust my skills.

Despite her trying experiences, Shauna did not get shaken, and did not make mistakes,

contrary to the expectations of the manager. She did, though, suffer physically and emotionally from the experience. She said:

So she expected, having them follow me, having all the nurses watch me, that it would make me so nervous and scared. It didn't make me nervous and scared. She expected me to make mistakes, like that BCIT girl, and then she would fire me. But I didn't. I must say, it did shake me up. When I left at the end of the shift and got on the bus, I just cried my eyes out. But I would never cry in front of her. One time, particularly, I got on the bus, and as soon as I sat down, there were tears rolling down my eyes. [I was thinking] "How long can I go on with this? How long do I have to take this? This is too much for me. This is too much for anybody". One time I fasted for five days, and I prayed, I prayed, I prayed ..for intervention from God. And then I went to see a counselor. I didn't sleep at night...but here I am! Standing, ready for another fight!

She had this to say about the manager:

She meant to break me. I think she meant to destroy me. She single-handedly tried to destroy what I had worked for so hard - my career, my whole profession, and me. In the end, she was too big to come and say "You know Shauna, I judged you wrong, and the whole thing got out of hand." Instead she said, "Oh, you're very stoic". Because she tried to destroy me and it didn't work. And instead of coming to tell me "Shauna, you're a good nurse, you've proved yourself, I've misjudged you" she said "You're very stoic," and then tried to say what got lost in the whole communication, nobody was hearing each other, nobody was communicating.

For a while after the incident, Shauna experienced intense anger toward the manager, which dissipated, leaving her feeling rather emotionally detached, but wary. She had a new assessment of the manager, and the working environment:

For a while I felt vindictive, I was out to get her, bring her to her knees. I'm like "She's not going to get away with this, I promise". But now I'm okay. I remember what she did, and I'm careful around her. I don't despise her, I don't dislike her, but I camp along. I just disrespect her because she lied. When I said that she had told me not to show up for work, and that she would resign for me, she said [in front of the union steward] "I didn't say that! How could I have said that? I cannot resign for you". I don't respect her because she lies, and she doesn't know how to be a manager, because if she knew how to be a manager, she would sense that the nurses around her are stressed out and the atmosphere of the nurses is not healthy. She even told me: "You know what? I'm sorry, but I had a bad day when I said all those things. I was stressed out myself."

When I interviewed the manager, we touched on this episode. She said that she had come back from holiday, and had to fire two people. She did not express regret about the incident, but did express frustration at the restrictions that the union put on



her in regard to being able to fire people when she wanted to. This was in the context of discussing her feelings of a lack of real power, and lack of support both from upper management, and from front-line staff. She said, "A unionised working environment is one impediment that middle managers often encounter"

She described the lead-up to the targeting episode:

One nurse came in to talk to me on behalf of the entire staff of the floor, and due to the seriousness of the complaint, I called in two more nurses and they gave me a list of problems this new nurse was creating - the lack of knowledge and skills and decision-making caused by this nurse compromised patient care, which was true. Her lack of initiative or decision-making compromised patient care. They were saying they felt uncomfortable with this nurse. They were saying they would rather work short than work with this nurse, because working with this nurse means that by default we are participating in compromising patients' care and we cannot do that.

The manager expressed some frustration at the position she was put into by the complaints of the nurses. To dramatise the seriousness of their complaints, the nurses told the manager that they would rather work short [that is, have one less nurse on shift], than to work with the new nurse. According to the manager, they must have known that the manager would not, and could not, agree to have one less nurse on shift. They were thus asking her to solve the problem for them: but as the manager said in the interview, "I cannot say that you can work short. They can say that because they do not want to confront the problem". The only other option, from her point of view, was to fire the nurse, but she was restricted due to the presence of the union:

This is the impediment; I cannot always do what is needed. Nurse A is only doing 50% of the work but is getting paid the same. It would have been easier if I could have just replaced that nurse, but I couldn't do that right away. There are three different responses by a nurse who is being criticized: one who observes everything and improves, one who wants to do that but has no capability, and one where the attitude is not there, has no insight, gets defensive. If it were a private non-unionized environment you could just let the person go and hire somebody else. I think that unionism and professionalism are conflicting.

She rejected any possible accusation that her attempt to fire Shauna was racially

motivated:

And then you get accused of a lot of things too. You have to be able to overlook such accusations. A person could say "because I'm male I wasn't given this opportunity" - I mean I'm just using that as an example, or "because I'm black" she was discriminated against, and that goes against my principle that I would make such a thing, regardless of who says what. When someone says because of my gender or race she treated me this way I have to say "Of course I didn't, that didn't even cross my mind."

I also interviewed another nurse from the same floor (contacting her the same way as I had Shauna, by phone) and asked her about the circumstances of the community college student (referred to by Shauna in her interview) who had been forced to resign – I asked whether or not that student had done a practicum on that ward as a student before being hired. Mona said that she had, and that there had been "concerns" about her performance as a student.

She may have been intimidated, or nervous, I don't know – she was bubbly, she was okay that way..But – I think Hannah had her as a student, and she had some concerns about some weak spots, and helped her make up some care plans and objectives, but it didn't work out. I think she was hired, to give her a chance, but it didn't work out.

I also asked this nurse about the incident with Shauna. It turned out that she had been one of the nurses who had contacted the manager about shortcomings in the work of both Shauna and Mary. This is an excerpt from that interview:

M: When I went to talk to [the manager] about it, she said that maybe I had concerns because I have very high standards, but I said these are very basic standards of nursing, and the patients are at risk, it's unsafe, and I feel very worried when I'm working with them. [The manager] asked if I could oversee their assignments, but I said that I couldn't do that on top of my work, I'm not here to baby-sit, and anyway, it wasn't up to me, wasn't it up to Sheri, the educator, to do that kind of thing?

Q: What were your feelings throughout this time? Were you anxious?

M: Yes, I felt anxious and worried. Every time there was an incident, we brought it up to them [Shauna and Mary], but there was never any response. No responsibility and no accountability. We all have to take responsibility and accountability. It worries me when someone doesn't ask questions and they think they know what they're doing through just common sense. Each incident they were spoken to - it wasn't that we short-circuited the route – but it seemed to continue, we were talking in circles. It was worrying me. And we're a good team, we're all there as a resource, we support each other. So Sheri was involved at that point, and it snowballed

from there.

Q: I understand that [the manager] accused Shauna of giving the overdose, but it wasn't her?

M: No, on that night they had both been working together and neither of them was certified to give narcotics through a central line; it wasn't Shauna who actually gave the narcotic, it was Mary, and then the patient had to be revived with Narcan.

In this interview it is evident that Shauna's fate was tied to that of Mary – that the mistakes of each had a “halo” effect on the other. Mary, for whatever reason, had made a crucial mistake after a year of employment on the floor, of not treating a low blood sugar. This mistake happened within the first month of Shauna's employment there as a new grad. Although Shauna's mistakes were relatively minor and not life threatening, they were perceived not independently, but as part of the total number of mistakes committed by both nurses. For example, Shauna had made a mistake in carrying out an order for a change of rate and solution of IV fluid. Each minor mistake accrued disproportionate significance in the eyes of the other nurses on the floor who were in a state of anxiety due to what they saw as a “close call” in the blood sugar incident. This anxiety reached a crescendo when Mary allegedly made the second serious mistake of giving Demerol too soon after a previous narcotic, which depressed the patient's respirations (It is not clear if the narcotic had been given too soon according to the doctor's order, or too soon in terms of the patient's condition). Another nurse had to give the patient Narcan to restore adequate respirations. This dramatic moment was etched on the consciousness of almost every nurse on the floor. The mistake was compounded by the fact that the narcotic had been given through the central line, by a nurse who was not certified to do so. In the explanation by Mona, this breach of protocol was just as serious or salient in her mind as the error or misjudgement of

administering too many narcotics to the patient.

Mona stated that both Shauna and Mary were working the night shift together. Her account, however, gives rise to some questions. Why had Mary given the dose without assistance or advice from a more senior nurse? Usually four nurses work on night shift, with one of the more senior nurses assigned as charge nurse. Was the charge nurse aware that neither of the more junior nurses was certified with central lines? Had the two junior nurses been left alone on the floor, while the senior nurses were on break or busy with other patients? Yet, Shauna was not aware of a narcotic overdose until I told her during my initial phone call to her, nor was she aware of any breach of protocol concerning central lines. Possibly she was not even present that night, but implicated in the story as it made its way from nurse to nurse the following day.

Shauna said that about two months or so after the targeting incident, she unexpectedly encountered Rita in the lounge – a nurse she suspected had reported to the manager about Shauna's mistake regarding the IV fluid:

Like, Rita, two weeks ago. First time she would talk to me since the whole incident. She would say Hi and then she would kind of look down, or she would kind of avoid me sometimes. But one time we couldn't avoid each other, we met in the lounge, and her and I were just by ourselves. The tension was there. So I said, "Hi, how are you doing?" And then she mentioned it: "Oh, um you left A ward and you went to B ward" I said "yeah". She said "I heard the whole scenario and I felt bad because it looked like I contributed to your leaving and so forth. I'm not like that. That's not me". I'm like – "Okay". But I'm remembering that it was her – she was the one who came to me and said "Oh, Shauna, you changed the rate, but not the solution [from NS to D5W]". And now she's telling me she doesn't rat on people.

Rita had told me in an interview that she is not happy on the ward and wants to leave.

The manager never assigns her as charge nurse, she said, which is insulting, since she is senior. If she calls in sick, the manager phones her at home, to verify that she is sick

(which is an infraction of the collective agreement). I told Shauna that Rita, too, considers that the manager criticizes and harasses her. Following is an excerpt from the interview:

Shauna: But why if you are in that position, in that situation, you would be more sensitive to - you know what you went through and you know how the manager is - why [would you do that], to get favoritism from the manager?

Me: I don't think she reports on people.

Shauna: You know, I believe that. I kind of see her after as more, like more genuine after that. Actually when she told me that, I believe that, but I still know that she was the one. Like I said, the environment, the situation, caused her to do things that she would not normally do. I think the environment pushes her [and others], contributes to the whole atmosphere of whatever's happening in the hospital.

Me: Perhaps she told one or two of the other nurses and it got to the manager second hand.

Shauna: It could be, it could be. Looking at her and seeing her, I kind of feel that - like she just wants to stay out of the whole dynamics of politics of the whole place, and just do her own thing. I can see that she just wants to do her job, the best she can and just go home. I kind of see her like that. So her and I talked and we kind of put things out - and I'm like - it's okay. I don't blame anybody, you know. It's happened. And so basically that was the end of her and I and the situation. And I think I'm more at ease with her, and she probably is more at ease with me, because we got this onto the table.

Shauna found that talking about the incident with Rita had cleared the air between them and had decreased the tension. She was not altogether convinced that Rita had not reported her, but she began to think once again about the interactive environment of the floor, and how it could be affecting nurses without their awareness, causing them to act in ways that they would not ordinarily act.

I guess maybe it's the environment. You see, I'm finding things with everybody. And I'm sure it's not them. I'm sure it's not them as a person. But it could be the result of the environment that they're in. If I say to them "Hey you are this way" they might think, "Oh my god, I didn't know that. Was I? Am I cold? Was I not supportive of you?"

Realizing that the work environment was affecting her health adversely, Shauna began to make plans to move on, once she had achieved her goal of acquiring proficiency in acute care skills:

I want to get out of there eventually. There is no way I'm going to stay here, because this is not conducive to my whole wellness, my whole health. Anxiety. My stomach is tight, and my nauseated feeling, and I'm moody and grouchy. I don't sleep the night before going to work. I have set a deadline. I have a plan. But I will leave on my own terms. I want to learn. I love to learn, okay? So I'll learn whatever she wants to teach me, but I will take it and I will run. You teach me and I will run with it. Okay, you can't take it back from me now, I'm gone.

Shauna endured about one and one-half years on the ward, working part-time while finishing her nursing degree. Then she took further training in a specialty, and about one and a half years after the initial interview, got a job at another hospital at which she was doing well and was happy. On reflecting on her experiences on A and B wards, Shauna had this to say about the manager and about health care generally.

Because of the result of the whole system, bureaucracy, and the health care system shifting and there are so many changes happening right now. I think she is caught up in that. I think she's [the manager] caught up in the whole system, and she's willing to do whatever it takes to climb the ladder. We are all caught up in that, and we just try to catch up with what's going on, and trying to adjust, change is so hard. I think [the manager] is a decent person but I think that she's caught up in the whole thing – trying to make it, and trying to be one of the guys, or trying to make it to be hospital manager and to be successful. She's Oriental, too, so she has to prove herself. Like everything she does, in the end it is always the patient, the nurse is just the means to the patient. "I'm the manager of patient care" It has to do with the system. There's a lot of change happening. We need to educate nurses more about what is happening around health care. Management needs to give paid workshops and courses, give back to nurses, to say, "We recognize that you are the force, you are the persons behind the caring."

### **The Case of Susan**

I contacted Susan through the snowball method – I had asked interviewees and acquaintances if they knew of any nurses having "troubles" on the ward. Two interviewees and a union steward told me that they knew of such a nurse, and I asked them if they could each on my behalf contact the nurse in question and give her my telephone number. Three nurses contacted in this way telephoned me and after I explained the purpose of my study, consented to meet with me and be interviewed.

Susan and her union steward already had some notes they had taken during a

meeting between the manager and themselves. With Susan's permission, I was allowed to see and copy the notes taken during this meeting. In addition, on the advice of the steward, Susan was taking ongoing notes, which she shared with me, about work situations and encounters with the manager, which she considered a protective measure. I also taped and transcribed several interviews with her over a period of several months.

Susan told me that she had transferred from an extended care floor to the acute care floor, having had previous experience in acute care. For three months after she was hired, (the "probationary period") things seemed to be fine on the ward, despite the fact that the union steward on the floor had warned her at the beginning that she could possibly run into trouble because the manager on the floor "seems nice at first, but she is ruthless":

[The steward] told me that she herself had a really rough time from the staff for a whole year after coming to this floor from extended care, because they think you don't know anything [when you come from extended care].

Susan said that as soon as she started on the new floor, mistakes were pointed out to her by co-workers and by the manager. The mistakes were minor, however, and did not seem to affect her standing on the floor during the first three months or so. For instance, the manager called her aside in the medication room and pointed out that Susan's fluid balance sheets were not being filled out properly. Susan told me that she had felt nonplussed that such a minor matter should have been brought to her attention by the manager – normally, she said, she would have expected the nurse who had noticed this to leave her a note about it. She then asked another nurse on the ward to go over with her how to fill out fluid balance sheets properly: She learned that she was

expected to not only record the quantities of fluid taken in and emitted by the patient during the shift, but she was supposed to total them up before she left. Not having done so meant that the nurse on the next shift had had to do the calculations for the previous shift. Normally nurses try their utmost not to leave any tasks undone, for fear of stirring up indignation among those in the next shift. If a nurse has been really busy, however, and cannot complete all her designated tasks in 12 hours, she typically would look at the assignment sheet to see who was taking over from her, and if the next nurse is known to complain about such things, she might stay late to complete them. If the next nurse is known to be lenient, the nurse leaving the shift would point out what she had left undone, with an apology. Susan had been unaware of this norm.

In another incident, Susan hung a bottle of lipids on a patient's IV pole without noticing that another patient's name was on it. Another (senior) nurse pointed out the mistake to her. Susan explained that the reason she did not check for a name is that in the hospital where she had previously worked, lipid bottles always came up from the Pharmacy without name labels, since the contents were always the same. Susan said that the other nurse looked ill humoured and elected to fill out an "incident report" about the matter, which then came to the attention of the manager. It is possible that Susan did not appear contrite enough about the mistake to the other nurse, or appeared to the other nurse to take the matter too lightly.

After about four months, the manager began to make several complaints to Susan about her work performance, and suggested that she should go back to extended care. The following is an account of an interview between the manager and Susan, with the steward present, as Susan remembered it:



The manager said "about Mrs. X in Room Y. The day before yesterday her daughter came to visit in the morning, after you were working night shift, and complained that her mother was cold and lying in a wet bed, and she was going to write a letter about it". I said "That's strange because Mrs. X was 'with it' [that is, not confused] and was up to the bathroom and using the bedpan all night". I told [the manager] that yesterday morning I asked Mrs. N in the same room, who is really "with it" if she remembered the patient in the bed beside her who had been found lying in a wet bed the day before. I asked her "Do you remember about what time that was?" She said, "It was about 8:15 or 8:30". I last checked that room at 7:00 before I went home, so there was at least one to one and a half hour before anyone else checked her.

By this time, Susan suspected that she was about to be targeted. Julia, a union steward working on the same floor, had told her that nurses were "saying things" about her. She therefore had a steward present, was taking notes every day, "watching her back", and had an answer for the manager. The manager, however, had a list of allegations, and every time that Susan tried to refute or cast doubt on one allegation, the manager went on to another one. The interview went as follows:

Manager: The daughter complained to the doctor, and she was going to write a letter about it, so I had to follow it up, didn't I? Also, when you filled out the ADL [Activities of Daily Living] sheet on that patient, I noticed that in the slot where you record the time, you had put 0730 to 1930, instead of 1930 to 0730. There are other matters. For instance, you put Mr.B. to bed with his TED stockings on one day.

Susan: Mr. B. was up and down from bed to chair all day.

Manager: Someone told me that you were looking at your rotation at 9:00 in the morning one morning.

Susan: People are looking at their rotations all the time.

Manager: There are other details that you don't pay attention to. For instance there is the matter of putting up a bottle of lipids that had another patient's name on it. The nurse who made out the incident report about that is worried, psychologically, that this might lead to medication errors, since it is important to always read the labels on things.

Susan: This has no relation to possible medication errors. I have 8 years experience with parenteral nutrition. In X hospital, they did not even have patients' names on the bottles of lipids, they just kept them on a shelf, because all you have to know is whether it is 10% or not; nothing is ever added to them.

Manager: This is not X Hospital. You have to do things here according to protocol here, and the protocol here is that bottles of lipids have the patient's name on them, and you have to check that.

Susan: I will do so in future.

Manager: It may be too much for you to be learning new things at this time. Technologies are always changing. Maybe you would be happier to go back to ECU.

Susan: I am happy here. There's not much here that is new to me.

Manager: Well, what do you suggest?

Steward: Well, how about weekly meetings between Susan and yourself, and you can let her know what concerns you have.

Manager: All right.

[meeting adjourned].

The above interview illustrates a negotiation between manager and front-line nurse, who each put forth competing interpretations of events in order to further their respective aims. The manager's starting position is that Susan is not practicing competently and should transfer back to extended care. Susan's position is that she is competent and she is going to remain on the floor. After recounting four infractions (Mrs. X in a wet bed; the ADL sheet; Mr. B. in TED stockings; and Susan looking at the rotation), the manager's position has not changed. With the fifth infraction (hanging up the lipid bottle), however, Susan's answer reveals that she has some knowledge about the matter that the manager does not have – that is, that in some hospitals, they do not put a label with the patient's name on the bottle of lipids. This weakens the manager's position, which then shifts to "If you're going to stay on this floor, then you have to follow our protocols in the future". Susan's position changes to "I have violated a protocol, but will not do so in the future". The manager tentatively suggests that Susan should transfer back to extended care, but Susan insists that she is going to stay. The union steward suggests a remedy for the differences in interpretations.

The next incident Susan remembers pertained to two telephone conversations between the brother of a patient, and two nurses – Patsy and Susan. There were several nurses sitting in the nursing station, when Patsy answered the phone and could be heard telling the caller that she could not get the patient out of bed and bring her to the phone, because it would be too tiring for her. Susan said that Patsy sounded as though she was having an argument with the person on the phone, and she then hung up. A moment later the phone rang again, and Susan picked it up. She recounted what happened next:

The other phone rang, and I picked it up: "What was the name of the person I was just talking to and what is your name?" the man said. I said, "My name is Susan, what can I do for you?" He said that his sister is a patient on our ward, he just found out that she had been admitted, and that she had lain for five days in a bathtub calling for help, and he really wants to talk to her; he sounded as though he might cry. I said "Well, maybe it's possible to roll her bed out to the phone. I'll find out if that's possible. Can you hold?" Lynn [another nurse] said, "You just undermined your colleague by contradicting what she said". I said: "He was really angry, he sounded like he was going to report us, I thought it best to try to defuse the situation". Patsy said to the charge nurse "What do you think I should do?" The charge nurse said: "Ask her [the patient] what she wants to do". Patsy came back a short time later wheeling Mrs. D in a wheelchair to the phone. Both Patsy and Lynn looked really angry.

In the above incident, both Patsy and Lynn perceived that Susan had "undermined a colleague". This had serious repercussions a week later, when Susan was working a night shift with Patsy and two other nurses. Upon arriving at the nursing station, Susan took report and learned that one of her patients had been bleeding from the stomach. When she went to the patient's room to check, she observed a very large amount of blood in the drainage bottle, and called the doctor to report that the patient was bleeding profusely. This is how she told the story:

I called the doctor right away, and he ordered Vitamin K stat, and two units of plasma. The Vitamin K came up and I gave it. Blood bank said the plasma would be ready in about 2 hours. I told Patsy who was charge nurse that I would need her to hang the plasma when it came up since I was not certified in central lines yet. She said "Sure, no

problem”.

So far, the shift was uneventful in terms of interactions between members of the working group. Susan's patient had a central venous catheter (CVC or “central line”) through which he was to receive the infusion of plasma. Susan had not yet taken the in-service given by the nurse clinician that would authorize her to work with CVC's, so she asked Patsy (the only nurse on shift who was “certified”) if she would hang up the plasma when it arrived, and Patsy agreed. Shortly before the plasma arrived, however, a patient at the other end of the hall started to yell and swear very loudly, and Patsy, looking frazzled, called the security guards to quell him, saying, “We can't have this shouting”. (Reflecting on the issue of drug-addicted patients discussed in Chapter 6, it will be remembered that patients who yell and swear at nurses can cause acute distress).

The plasma then arrived at the same time that three members of the security team arrived. Patsy and the security guards went into the agitated patient's room.

Susan continued the story:

I asked her through the intercom if she could hang the plasma. She said that she was busy. I asked her if Rochelle could replace her with whatever she was doing so that she could hang the plasma. She said, “I'll just be five minutes.” In about 15 minutes she comes out of the room with three security guards and another nurse, pushing the patient in a Geri chair. He was still shouting. They push him down the hall near the nurse's station. Patsy stood there talking to the man's wife. “Patsy” I said. “Could you hang the plasma now?” She picked up the plasma and walked into Room 123 with me. She didn't say a word. She got to the door and said, “I told you that I would be five minutes, I couldn't leave, I was busy”. I said “But this patient is bleeding, he needs the plasma, and it has been sitting there for almost half an hour”. We went into the room, and Patsy hung the plasma. She told me “I'm going to speak to the manager about you. You're not a team player!” She said that she was really upset and that she was going to talk to the manager about me, and tell her that I said, “I'm going have you replaced”. I told her I didn't say that, I said, “I asked you if Rochelle could replace you at whatever you were doing in that room so that you could come out and hang the plasma”. She said, “Well, I'm definitely going to talk to the manager”. A few days later the manager called me into her office, and she didn't want to hear anything I had to say about it. She just said, “Patsy told me what happened, and so that is what happened”.

It is apparent that Patsy's perception that Susan had undermined her a week earlier influenced how she perceived what Susan said over the intercom. She believed that Susan had threatened to have her "replaced". Such a threat could be taken seriously, it is assumed, in the context of restructuring (as discussed in Chapter 6) where people were being unpredictably "replaced". Moreover, Susan's misheard comment was made in front of three security guards, another nurse, and the patient's wife, so that Patsy doubtless perceived that Susan was further undermining her position. Both nurses were very tense – Patsy, because of the agitated patient who was extremely noisy; and Susan, because her patient needed plasma right away. Adding to the tension of the situation was the fact that only Patsy was certified to hang the plasma. Had Patsy felt less tension, she may have decided that the security guards and the other nurse could manage the agitated patient, and she could safely leave that room to assist Susan. Had Susan felt less tension she may have decided that since Patsy was very "frazzled", she would go in person (rather than calling over the intercom) to ask her if she could help with the agitated patient while Patsy hung the plasma.

One and one-half months later, the incident of "the code that was not a code" (described in Chapter 5), was apparently the last straw. A few minutes after this incident, the manager had exclaimed in the nursing station in front of everyone, including the annoyed doctor with whom she had been discussing the code, and the charge nurse: "I'm at the end of my rope with her!" By the next day, Susan perceived that some of the other nurses were looking at her "strangely" and interactions were also "strange". This is similar to Shauna's perception that "I think I see people looking at me differently". Susan said:

I went down the hall to the room where Joanne and Nellie were working with two patients. I said to Joanne "Your patient Mrs. P. has a splitting headache. Can I give her some Tylenol plain?" "Oh sure" said Joanne "she wouldn't take it from me". I gave the Tylenol to Mrs. P. A bit later I needed to get into the narcotic cupboard to get some medication for one of my patients, so I went down the hall to the same room and asked Joanne if she had the keys. She said, "No, I gave them to you when you gave Mrs. P. the Tylenol #3"; I said: "I gave her Tylenol plain, not Tylenol #3. Did I say Tylenol #3?" "Yes, you did", said Nellie, the other nurse in the room. Joanne dropped the keys under the curtain for me without saying a word.

The next day, a labour relations officer (LRO) from BCNU phoned Susan at home and said "Susan, what's happening!" The LRO said that she had received 3 anonymous phone calls that morning from nurses who said that they had concerns about Susan's nursing practice. They said that Susan was not maintaining nursing standards, that she had jeopardized patient safety, and that they did not feel safe in leaving their patients when Susan covered for them. They also alleged that Susan had left on breaks without reporting off, and one night had left to go home sick in the middle of a shift without telling anyone. Susan replied that she "had been following the book" ever since the first meeting with the manager and that the allegations were not true. The LRO said, "If you have been following the book, then you'll be all right". But she advised Susan to phone the manager immediately to make an appointment with her, adding "She created this mess, so it's up to her to clean it up." The approach that would be taken, the LRO said, was that Susan was to ask the manager "how she can help you to be able to go back and function in that ward". She advised Susan not to go back to work on Sunday, because "they [the other nurses on the floor] are gathering around like a pack of wolves". Following the advice of the LRO and coached by her on what to say, Susan immediately phoned the manager to arrange to meet with her. The appointment was made for 3:00 pm that afternoon. Susan said:

I got to the nursing station about 1450, and sat and talked for 10 minutes with three

nurses who were there. They were friendly. Eva asked me how my back was, and mentioned that two other nurses were off sick from transferring heavy patients. She looked sort of concerned or worried. Two weeks ago Eva told me that [the manager] was asking her how I was doing, and if she had any concerns about me. She said that she told the manager that I was doing fine. While I was sitting there, Joanne came through the nursing station to the med.room, and when she saw me she had a sort of guilty or embarrassed look on her face. I went into the med. room to get a glass of water and said "Hi Joanne". She said "Hi. How's your back?" I said getting better, but that this floor is too heavy for us middle aged nurses, we made a little joke about when exactly is middle age. After I went back to my chair in the nursing station, I saw Mava coming down the hall, and when she saw me, she quickly turned her face away.

The manager arrived and she and Susan went into the conference room. Susan reiterated what she had said over the phone and, coached by the BCNU officer added that since there was a perception among some nurses about her nursing practice, this had to be addressed, and she hoped that the manager could arrange some solution or mechanism to resolve the situation so that Susan would be able to have a work environment that she could function in. Susan said:

She [the manager] said that she did not know anything about the anonymous phone calls, but was I surprised about the phone calls? I said yes, I was. She said "Why? Because I have told you many times in the past about the concerns, and there is a consensus on the ward about it. Some people are saying that you are overconfident. One nurse even asked at the ward meeting 'What happens if someone else makes a medication error, am I responsible for it?' and I said I don't know, I can't discuss that here. Another thing that makes them question your judgment is the night you went home after you injured your back. Mava, who was charge nurse, phoned me at 10:00 pm and apologized since I was taking the next day off to catch up on things. She said that you had wanted to stay on and work the rest of the night after taking some Tylenol #3's, and she questioned your judgment about working under the influence of Tylenol #3's". I said "I told her I was going to take just plain Tylenol, not Tylenol #3.

It is pertinent to note here that Susan would not have been able to get Tylenol #3 tablets for herself, since they are stocked in a narcotic cupboard that is locked; a nurse documents each time she takes out a narcotic for a patient; and at the beginning and end of each shift, two nurses count the narcotics to make sure they are all accounted for. In addition is the obvious fact that Tylenol #3 would not likely render someone incapable of carrying on with their shift. Susan continued: "The manager said, "Anyway,

she phoned me and told me she didn't know what to do. Since there was no one to replace you, they had to block four beds, and work short handed".

The manager is presenting the scenario from her point of view. This version of events involved a disturbed and anxious charge nurse who phoned the manager (who was at home trying to catch up on things) for advice about an allegedly unsafe working environment due to an incapable co-worker. The manager had to make a quick decision based on the interpretation of the situation by Mava, the CN. She advised Mava to send Susan home, and notify ER that the remaining empty beds were blocked [that is, the ward could not accept any more patients]. As a result, the remaining nurses had to take on the patients of the departed Susan in addition to their own heavy patient loads. Whatever the explanation may be from the point of view of Susan, it was far too late for the manager to revise the version of events already established by herself and Mava in terms of explaining to the other nurses the reasons for their increased workloads, and to the ER and higher management the reasons for the four blocked beds. Probably it was also beyond the scope of the manager in terms of her own workload and time, to investigate the matter further.

It became evident in the interview that the steward's advice and coaching to Susan to take the initiative in requesting a meeting with the manager gave Susan some control over the direction and outcome of the meeting, that she would not have had if she had gone into work that day unprepared. Susan continued:

Then she said that she was glad that I called to have this meeting and if I hadn't called and if I was working today, she would have scheduled to meet with me at 2:00 anyway. She said "I am here as your coach". Mostly I just kept quiet and nodded. Then, with a big smile on her face and hesitating a bit, she says, "I have to tell you that I have never had so many calls at home before about any nurse as I have about you. Some nurses tell me 'I don't want to be in charge when Susan's on'". I said "Oh?" and she says "That's why I



haven't done your evaluation yet, because it would be so bad right now, all negative things. I wanted to wait until you are doing better. Since I gave you the full-time position after your probation, I have to take responsibility for what has happened and see this through". Then she asks me "Tell me, is there something going on with you?" and I said "Well, I've been feeling very tired lately, my back still hurts, and someone close to me is really ill". So [the manager] says "What should we do about the situation, how should we resolve it?" and I said, "I was hoping that you would suggest something". So she says "What I would suggest is that you take a stress leave for two weeks, or until the employee health nurse says it is okay for you to come back. And you could go to the Employee Assistance Program [for counsel ling]. The Employee Health Nurse could arrange that." I said, "Yes, that sounds fine"

Susan said that she went to the office of the occupational health nurse who agreed that she should go on a stress leave. As she and the employee health nurse approached the nursing station to finalize the sick leave, she said that at that moment she perceived the windowless nursing station as "ghastly and hellish".

One day during her sick leave, Susan had to go to the manager's office to hand in a note from the occupational health extending the sick leave. They had a friendly conversation. The manager said how disappointed she had felt when she interacted with Susan in the past months. She gave the example of Sylvia, another nurse who had been more grateful for her interventions:

She said that after her meeting with Sylvia [the other nurse who had transgressed] she wrote out a list of objectives for her, and said that she would be watching her. She said that Sylvia thanked her for helping her to be a better nurse. Then [the manager] said "I never got that kind of reward from you". She also told me that one weekend she had felt so drained from the situation with me that she had spent the whole weekend hibernating in her bedroom, not even talking to her family.

At the end of two months, Susan went back to work, a day earlier than indicated on the medical leave slip, because the staffing office had phoned to say that she was expected to work that day – a Sunday.

When I got to the nursing station, I was greeted by friendly smiles and "Hi Susan" by most of the nurses there. People were beginning to say by Monday and Tuesday that it had been really nice of me to come to work on Sunday before my medical leave was up, when I would have had every right not to come in. Tuesday night shift I had a heavy load,

and it was non-stop urgent situations with my patients - one woman starting a lower GI bleed, and blood pressure "bottoming out", blood transfusions, bed in trendelenberg; another one having an insulin reaction, another one who needed to have dressings on her edematous feet that had weeping sores. I only took a one-hour break at 0500 instead of the usual 2-hour break.

Susan said that the next night was better, but she worked the whole night without a break so that she could go slowly and unhurriedly, knowing when she left that everything was done. She said that she was feeling happy about being back at work, and relieved that lingering fears she had had that she might not cope were groundless. Transcripts from the rest of my interview with her illustrate a process of reintegration into the nursing work group, and the reclamation by Susan of her status and identity as a competent nurse:

Some nurses knew that I had a horrendously busy night and had coped okay... On the next batch of weekdays that I worked, I didn't sleep much the night before... I had prepared my set of objectives, and took it to work with me for the next three days, expecting [the manager] to call me for a meeting, but she never did.... One morning Julia who was going home from nights, suggested as a friendly supportive move that I should take a certain room, as it was a nice assignment. About noon, though, one of the patients in that room had a heart rate of 31 and was symptomatic. I asked the CN to call the resident stat, and told her that I had put atropine at the bedside in case they decided to order it (which they did). At the end of the shift next day, Marnie coming on to night shift had a sort of admiring look while I was reporting to her about that particular patient.

## Discussion

Targeting is a complex matter. It is evident in the cases of Shauna and Susan that all nurses on a floor where targeting is taking place feel distress, including the manager. There were some targeted nurses, like Jill and Kay who "disappeared from the face of the earth" who did not survive the episodes. In the other cases observed, however, there was an identifiable trajectory that ended with the reintegration of the targeted nurse into the same or an adjacent work group. The process of reintegration begins with an admission by the targeted nurse of wrongful acts, and a

statement that she is ready and willing to accept the help she needs. An explanation for her aberrant behaviour is constructed, and a plan for her rehabilitation formulated.

While previous studies identify perpetrators and a victim in the targeting episode, in this study there do not appear to be conscious perpetrators as there were in the studies by Calliste, Das Gupta, Lemert, and in the mobbing literature. Although specific nurses initiate the targeting process by voicing complaints about the performance of one of their co-workers, this is apparently not done from malice or ill intent. It is done due to a concern for upholding the standards of nursing, and from fear that they might themselves be accused of not upholding those standards if another co-worker breaks protocol. Jessie, a former head nurse who circumvented a targeting episode (discussed in Chapter 9) said about a nurse having "troubles", "First, we had to remove her from the unit, from the area of stress, because the other nurses were getting very antsy working with her because she was making medication errors.

As things progress, the other nurses on the floor begin to perceive themselves as the actual victims. Similar to the classic Lemert study, the targeted nurse begins to take on demoniac proportions while the "perpetrators" or initiators fear for their own safety. Other nurses watch the drama unfold with increasing unease.

The initiators belong to the "inside" group, and are perceived as good nurses who do not make mistakes. Indeed, in the case of Shauna, she identified Mona - whom she did not realize was an initiator of the targeting episode - as a "model nurse". The reputation of being good nurses is extremely important to the initiators. They do not perceive that they are targeting, but rather, that they are upholding nursing standards of practice, making the floor a safe place for themselves to practice in, maintaining the

prestige and reputation of the ward and that of the nurses working there. By “safe” these nurses mean that they have confidence in the skill and attentiveness of the other nurses so that neither patient safety will be jeopardized, nor their own reputations as competent nurses. There is no doubt that they felt true unease in the cases of both Shauna and Susan. The office workers in Lemert’s study (1962) were also uneasy – at first because they felt incapable of dealing with a difficult individual (like Mona who expressed frustration at not being able to change the behaviour of the two nurses); and then because they feared retaliation from the targeted individual who had assumed such demoniac proportions. The initiators in this study do not fear retaliation from the targeted nurse – they fear fallout from what they perceive as growing incompetence by this nurse. They want the cycle to stop, and they expect that the manager or nurse clinician will undertake to either rehabilitate the nurse, or failing that, to expel her from the group.

Targeting is the culmination of and focal point for general unease on the floor. Both unease and targeting appear to have increased during the nursing shortage and the era of restructuring, and it appears in this study more likely to take place on acute care floors rather than on ECU or critical care floors. With the intensification of work, senior nurses on acute care floors have no time, patience, or willingness to supervise and assist new nurses with their learning needs. Yet they are keenly aware, from their memories of being new nurses themselves, that the new nurses had much to learn. They anticipated that they would see mistakes and shortcomings, and they did. With apprehension and mounting distress, they received reports from a few other nurses on the floor about mistakes. They became hyper-vigilant. The situation became

unbearable from their point of view at about the same time that it became unbearable for the victim. They appealed to the manager.

Since the changeover from head nurse to manager, the manager has less time for direct supervision and observation of the work of the nurses on the floor, and has to rely on reports from nurses about other nurses. In the case of Shauna, the manager considered that she did not have enough money in the budget to allow more time for orientation for the new nurse, nor for her to "buddy" a longer time with a seasoned nurse. "Buddying" would doubtless have had the effect of helping the new nurse to integrate into the work group from the beginning, and would have been a boon to the seasoned nurse who would have had her load lightened, and would have had a stake in seeing that the new nurse succeeded.

The manager had to be seen as doing something to solve the problem. She was walking a fine line between staying in favour with the "in group" of good nurses, and her need to recruit more nurses to the floor. She also had to justify having hired the nurse in question in the first place. The easiest solution would have been to quietly and quickly fire the new nurse. In the case of Shauna, the manager was prevented from doing so by virtue of having violated a clause of the collective agreement, when she called Shauna into the office without the presence of a union steward. In the case of Susan, the complaints reached their full intensity only after the three-month probationary period, after which the rules of the collective agreement do not allow a manager to fire a nurse without showing good cause. The manager in each case felt anger and frustration at the limitations imposed by the union, and anger because of their own powerlessness in the situation. In the case of Susan, the manager felt anger at the new

nurse for not living up to her expectations, and casting doubt upon her ability to make good hiring decisions.

Those witnessing but not taking an active part in the targeting episodes felt unease. Members of the working group felt distress that for some escalated to a point that resembled a kind of hysteria. They felt powerless to change the course of events. Resolution came in the form of the temporary or permanent removal of the new nurse from the working group. If the removal was to be temporary, the mistakes of the new nurse had to be constructed as a temporary aberration that could be rectified by her taking time out. A plausible cause of the temporary aberration had to be constructed, the removal of which would pave the way for her eventual reintegration into the working group. After six weeks, Susan was integrated back into a now much calmer working group, whose somewhat conscience-stricken members were eager to give themselves and the new nurse a second chance. In the case of Shauna, she was integrated into an adjacent work group.

Lemert (1962) also notes the discomfort and distress of people in the workplace who are taking part or witnessing an exclusionary episode. In his study, however, the victim was usually banished permanently to another office, and/or eventually to the case files of a mental health worker - classified as a paranoid. Neither in his study, nor in those of Calliste and Das Gupta, nor in the mobbing literature, is the victim reintegrated into the working group. In the Calliste and Das Gupta studies the main perspectives presented are those of the victim, with only one comment from the point of view of a nurse who is not a victim, who states that "you have the ward divided pro and con the singled out nurse". In these two studies, the psychological state of the other

nurses on the ward is not explored. In the present study, it did not appear that targeting was a management tactic to divide and rule, but rather as a tactic by the manager to survive as manager.

In Lemert's study, the excluded office worker was male, considered "difficult" and was perceived by his co-workers as potentially dangerous in that he might retaliate, or become a potential "whistle-blower". This was the basis of the psychological and physical suffering of the leaders of the exclusionary coalition that formed in the workplace. In Lemert's study the perceived danger of the targeted co-worker, from the point of view of the members of the "coalition", was increasingly magnified during the trajectory of the exclusionary act. Similarly in the present study, there was an increasingly heightened perception of nurses on the hospital floor that the targeted nurse was posing a danger to themselves, the ward, and to the patients.

In the cases presented in the present study, both the victim and the initiators were female. The floor leaders did not state that they wanted the target nurse expelled, only that there be some resolution to the intolerable situation they were experiencing - which they left up to the manager to resolve. They did not fear bodily harm from the victim, nor that the victim would be dangerous to themselves or to the floor once expelled from the working group. Their belief was that the status quo was dangerous - the longer the targeted nurse stayed on the floor, the more incompetent she would become and the more "unsafe" the floor would become until eventually a catastrophe might happen. Their fears about incompetence (defined as making mistakes) became a self-fulfilling prophecy for the new nurse. In their minds, however, the manager's action of expelling the nurse from the working group had averted the catastrophe that might

have happened. The action reassured them of their belief in their own competence, and it maintained the reputation of the floor as a high functioning one.

The allegations against the targeted person in the Lemert study were somewhat vague – he was irritating, or had some other unlikable characteristics. Researchers in the field of mobbing (for example, Einarson, 1999; Leymann, 1999) found that the method of predicting targeting or bullying by compiling characteristics of targeted individuals, has not yielded fruitful results. In the Calliste and Das Gupta studies, the targeted nurses were accused of minor infractions such as using the nursing station phone for personal calls, or talking too loud. It is possible that Calliste and Das Gupta (who are not nurses) did not know of or report other alleged infractions. In the case study of Shauna, serious mistakes had been committed by Mary, but not by Shauna herself. Due to these serious mistakes, however, the more minor mistakes by Shauna assumed threatening proportions. They contributed to the general increasing perception that things were not “safe”. Also, in both cases, actions of Shauna (such as not hanging up a unit of blood in time) and Susan (calling an unnecessary code) resulted in a “waste of resources” which, in the context of cost containment, was almost as compelling as life-threatening mistakes used to be.

In the Calliste and Das Gupta studies, the authors posit that targeting Black nurses was a management tactic to divide the nurses against each other, and thus maintain their power over the floor. In the present study the motives for targeting were not so clear-cut. While targeting was directed almost always toward Black nurses in the Ontario studies, in the present study I became aware of targeting directed toward nurses of varying ethnic origins.



As authors of the above studies acknowledge, the phenomenon of workplace bullying or victimization is complex. There is no doubt that such a phenomenon exists, and that this phenomenon is very evident in much of the data collected in this present study. The concept of "targeting" or "bullying", however, is not sufficient to describe and explain what is going on in the interactive environment of nurses. I first became aware of the limitations of the concept of "targeting" after reviewing the studies by Calliste and Das Gupta on the targeting of black nurses in Ontario, and then reflecting that this phenomenon was pervasive in all nursing environments whether or not black nurses were present. Literature on "horizontal violence" among nurses also seemed limited: while it was somewhat outwardly oriented in its characterization of this violence as "oppressed group" behaviour, it tended to focus the attention of the reader to something inherent among nurses that caused the behaviour. Much of the "mobbing" or "workplace bullying" literature, on the other hand, (which could be placed in the category of "organizational behaviour"), turns the focus of attention to the organization, which is seen as dysfunctional. In this perspective, it is dysfunctional in an environment that is demanding restructuring of the organization, and the harder it tries to comply, the worse is the outcome in terms of the negative impact on interactions, and on the health and well-being of its members, the cost to the organization, and in terms of lesser production. The manager as an actor in a "bullying" or "victimization" situation is responding to the impossibly severe imperatives of the job so that he or she either consciously or involuntarily becomes a "bully". This conceptualisation seems to explain the phenomenon better, but is still not complete. It does not, for example, explain why some managers fall into the "bully" role, while others do not; or why some front-line

nurses become victims, bullies, or witnesses while others do not.

Lemert's (1962) description of the effects of collective paranoia in an organization fits well with scenes that I observed. The front-line nurses in the cases of both Shauna and Susan were clearly feeling acute stress: for example, Tara - the nurse who grabbed the oxymeter from Shauna, and then "threw" it back, later apologized to Shauna for being short with her, and explained that she had had a patient who was "going sour". The next afternoon when Shauna received report on behalf of Tara about a patient about to arrive from the Emergency Room, Tara felt compelled to phone the ER and get them to repeat their report to see if the patient would be on telemetry, and to check whether or not Shauna had taken report accurately. To me, this demonstrated that Tara possibly did not feel confident about receiving a cardiac patient. To Shauna, it apparently demonstrated that Tara did not have confidence in Shauna's ability to take an accurate report.

In Susan's case, anonymous front-line nurses had made complaints to the manager, who had herself previously canvassed them about Susan's performance. They said that they did not have confidence in Susan's nursing practice. After the "code that was not a code", these nurses reported her to the BCNU. On an acute care floor, a "code" is a very stressful event, and is dreaded by all. From their perception, Susan acted in an inappropriately casual manner when she called a code, and when they found out that the patient had been designated a "no code" they doubted her judgment even more. They could not put their collective finger on anything to adequately explain to themselves their anxiety. They turned to the BCNU to sort it out.

Unlike in the cases described in the studies by Calliste, Das Gupta, and Lemert,

there was no division between nurses for or against Shauna and Susan that they could detect. As in the study by Lemert, however, there was generalized anxiety with physical symptoms such as fatigue in some of the actors in both cases. In the case of Susan, the manager stated that she herself had gone through a difficult emotional time, and had to “hibernate” in her room for a weekend. Thus it does not appear that the manager deliberately encouraged targeting as a tactic.

Susan thought that the nurses who had anonymously reported her to the BCNU appeared to be the same ones who averted their faces, as though feeling embarrassed or guilty, when they saw her in the nursing station. Others greeted her in a friendly or noncommittal manner when she went to the nursing station for her appointment with the manager. One had said to her previously that she had felt anxious on her behalf when she heard the manager asking nurses about her performance. Another nurse on the same floor later said that she was not even aware that there had been “concerns” about Susan’s performance.

When a legitimate “cause” of Susan’s behaviour was identified – her back injury and concern about the illness of a friend – the nurses who had doubted her competence and had reported her to the manager felt a sense of relief that there had been a legitimate basis to their anxiety and complaints. Moreover, the “cause” could be remedied: Susan was to go on sick leave and recover. During this period, the intensity of their feelings and memory of it diminished. On her return to the floor, they were expecting her to have been rehabilitated, and were looking for positive aspects of her nursing practice, which they found. On her side, Susan tried extra hard to appear competent and conscientious. She was reintegrated into the nursing workforce on the

same floor.

There were two incidents described in this study (involving Mary) where the nurses' failure to diagnose and treat symptoms could have had serious consequences. Although I did not observe any lead-up to the incidents in terms of negative comments by other nurses, or targeting or bullying, I did later interview a nurse (Mona) who said that she and other nurses had had "concerns" about both Shauna and Mary. Since I did not have the opportunity to interview Mary, I cannot confirm what her experiences were.

Evaluations of incompetence at other times seemed to be based on small mistakes that were cumulative in the minds of nurses, so that over time they loomed large and threatening. In some cases (for example, Jill, a graduate from a technical college), a cycle could be identified in which doubts in the minds of others planted doubts in the mind of the "targeted" nurse about her abilities, so that she made more mistakes, and "incompetence" became a self-fulfilling prophecy - a socially constructed entity created through a set of interactions. The expectation of mistakes in the minds of regular staff was greater for new nursing graduates who were not familiar to the staff, or who came from a less acute ward or from a stigmatised ward like extended care, or who showed traits like lack of confidence. It is not possible from this study to discern whether or not Shauna, as the sole black nurse on the floor, was targeted because other nurses had expectations about her performance because of her colour. It could have been a factor in a combination of "markers" such as her status as new grad, having worked on an extended care floor, and being associated with another nurse who had made errors. Susan, too, had to overcome the stigma or "marker" of having worked in extended care.

The socialization of new nurses who have graduated from a technical college was reportedly easier for them than that of university-trained nurses, who had a "tougher time". Due to the long rotations and practicum undergone by the former, their faces were familiar to the nurses on the floor where they were eventually employed. This was not always the case, however, as evidenced by what the manager told Shauna about Jill (the new grad who had been forced to resign) and by what Mona said about her.

In this study, most of the targeting incidents that I was aware of happened on acute care floors. It is not possible to say with certainty on this basis that targeting incidents are always more likely to happen on this level more than on others. Certain conditions on acute care floors, however, may make targeting more likely. These factors may include the following: Due to the intensification of work on acute care floors, more senior nurses are more likely to be irritable and tired, with little time or patience to give guidance or help to new nurses. Secondly, nurses on acute care floors may be more anxious about being able to maintain nursing standards under the new working conditions.

As described previously, the work on acute care is less predictable than that on extended care floors, and even than that on critical care units. On the ECU, unlike acute care floors, patient/residents there are almost all "no code" – needing no dramatic lifesaving interventions. The few in ECU who are "full code" –(and this is pronounced with trepidation, there) – are quickly dispatched to ER at the slightest sign of difficulties. The routine of ECU offers some security, stability and safety, as mentioned by May, a nurse of East Asian origin who said that she did not like the bustle and business of

acute care floors. On acute care floors, by contrast, there is less opportunity for routine, and more chances of the unexpected happening, although nurses often try to cling to routine. Even the ICU, though having sicker patients, is not as unpredictable as the acute care floors. The ICU is organized to deal with emergency situations quickly and conveniently, with all the technology and equipment readily available, as well as having resident doctors close at hand 24 hours a day to step in and assume responsibility for emergency situations. Nurses in critical care areas have learned a finite repertoire of actions for the finite number of emergencies that may happen: all possible scenarios have been practiced over and over, so that they too, become routine. Critical care nurses often have one patient (if ventilated) to care for, and at most, three patients. On the acute care floor, by contrast, nurses may have as many as 9 or even 10 patients, spread out over two or more wings or hallways, with markedly varying levels of acuity. If an unexpected emergency arises, there are no resources to deal with it on the floor, and the patient must be quickly moved to the critical care area. In addition, the nurses on the acute care floor have not had the numbers of years of experience, on average, that the nurses in critical care levels have, who have all worked in acute care in the past. Possibly due to the above reasons, there is far more tension and anxiety on the acute care floors than there is on the other two levels of care.

Susan, one of the targeted nurses discussed in Chapter 8, was excluded from the working group for one month (during which time she took a stress leave). The three nurses initiating or participating in the targeting event toward Susan, did, however, attenuate the potential effect of their actions by calling on the union to intervene. The intervention of the union labour officer, who coached Susan on tactics concerning the

nurses “gathering around her like a pack of wolves” were effective, as well as her coaching on how to initiate meetings with the manager, and what to say at the meetings.

The role of the occupational health nurse was also to act as a buffer between Susan and the anxious nurses taking part in the targeting episode. Due to her official position, the occupational health nurse (along with the doctor) was able to provide a legitimate reason for Susan’s transgressions of floor norms (stress) and to legitimate Susan’s need to take a stress leave. This deflected any blame away from the other nurses, and directed it toward a medicalized phenomenon that could be treated. It allowed Susan to be removed from the anxiety-laden situation until the anxiety subsided. The time out provided a way out for the manager, as well, who had seen the problem as insoluble.

Things cooled down, anxieties diminished, and the memory of the transgressions diminished. Nurses were more than happy to welcome Susan when she returned from her stress leave, and to perceive the positive attributes of her nursing practice. What they really wanted was a cohesive working group of nurses who worked well together and helped each other, and that is what they wanted the rest of the world to see. Susan, for her part, tried extra hard to conform to all group norms.

Shauna, on the other hand, did not have such a smooth re-entry into the nursing work group. Partly this was due to the interventions of the manager and nurse clinician, who insisted on calling Shauna in to their offices for interviews and “updates” – in full view of the other nurses in her working group – and insisted that Shauna formulate extensive “learning plans” as though she were still at the level of a student nurse. This

was stigmatising for Shauna, and set her apart from other members of her working group. It marked her for disrespect from her colleagues.

Another reason that Shauna's re-entry was not so smooth, may have been the lower acuity level of the floor into which she was to be integrated. Since she had been asked to leave the adjoining floor with higher acuity, the message was probably not lost on her new co-workers that Shauna was not good enough for the more acute ward, but she was good enough for the less acute ward. Esteem issues undoubtedly arose among members of the working group on the less acute floor. This may have been one of the reasons that Shauna was called into the offices – to send the message that she needed to improve to work on that floor.

Nevertheless, from the point of view of some nurses on the less acute floor, Shauna was integrated into the new working group with no difficulties. Certainly, her demeanour did not show that anything was wrong. One nurse I talked to (Annabel) was not aware that Shauna was feeling humiliated and angry, but rather, thought that all was well. On the face of it, the reintegration took place smoothly, and probably few nurses suspected the real reasons that Shauna subsequently resigned from the floor as soon as she possibly could.

Corroborating the crucial importance of mutually supportive interactions in the working group, and the negative effects of interactions that are not supportive, Asifa said:

It's very important who you are working with, your co-worker. If she is in good spirits, she is not complaining – probably she has a lot of anxiety coming from different other reasons, or whatever, but anyhow, when you are working with another person when she is in a very high tension state, and she is not in a good mood, she is not cooperative, she's giving a hard time to you. So you can't handle everything, it is difficult. I sometimes say, "Is it me that she's [acting like this] or is she the same to other people, too?"



Asifa is saying that the first impulse during negative interactions is to ask oneself “is it me?”. At the same time, she acknowledges, “probably she has a lot of anxiety coming from different other reasons” – an insight that could lead her and other nurses toward realizing the need for a collective response to what many nurses may be perceiving as private troubles.

## **CHAPTER 9 - NURSES CONFRONT TARGETING AND RESTRUCTURING: TACTICS OF RESISTANCE AND SOLIDARITY**

The wider communalities of the workplace, from informal kinds of camaraderie to more formal associations like trade unions, have a major impact on the character of work. (Erikson, 1990; p.31)

In the spirit of the aim of this study, it is important to enumerate and describe acts of resistance and solidarity among nurses, to provide models by which nurses can empower themselves, and to promote policy changes with respect to ameliorating the working conditions of hospital nurses. In this chapter, I describe examples of resistance to targeting and restructuring that I observed or that interviewees talked about, which range from individual acts of passive and active resistance, to collective acts that are formal and informal.

Formal action in the present study always involved the union, which defended individual nurses who were targeted, negotiated collective agreements, and launched public campaigns against policies of restructuring. Informal acts included individual measures such as calling in sick, resignations, and working out tactics and alliances among other nurses on the floor to circumvent targeting. Informal acts also included collective measures such as the collective undermining of certain accountancy procedures, rallying around an ill or a targeted colleague, and a vast array of social events through which nurses, consciously or unconsciously, built a sense of solidarity that mitigated against the negative effects of "ward politics".

### **Informal Tactics**

The most prevalent tactic of individual resistance to unpleasant interactions on the floor is to call in sick. As Erikson (1990; p.32) notes: "The standard indices of

dissatisfaction - calling in sick, filing grievances, and quitting altogether have long been regarded as hidden protest votes on the quality of work life". Many nurses choose to work night shifts or weekends, in order to avoid interactions that they identify as "ward politics". Some nurses who work only on a casual basis refuse to return to floors if they do not like the working environment there. Some nurses resign from the floor, and some even leave nursing altogether. Nurses who call in sick or resign, while feeling genuine illness or distress, are at the same time registering silent acts of protest.

Absenteeism and high turnover in the workplace - two types of individualistic responses to unpleasant or overwhelming working conditions - have been described in the field of workplace and organizational behaviour, which includes studies of nurses and other hospital employees (for example, Caudill & Patrick, 1989; Price & Mueller, 1981; 1986; Waxman, Carner, & Berkenstock, 1984). Absent from studies of nursing workplaces are reports about activities like "soldiering", sabotage, and pilferage that are reported in other types of work areas (for example, Gottfried, 1994; Roy, cited in Burawoy, 1979; Thompson & Ackroyd, 1995). These activities reportedly take place "beneath the surface of formal organization and the apparent consent of employees in the capitalist employment relationship" (Thompson & Ackroyd, 1995; p. 615).

In addition to passive types of resistance described above, numerous more active interactions by nurses to circumvent targeting were identified during interviews and observation on wards. Some nurses, for example, state by words or actions that they do not reply to adverse remarks about other nurses - their silence conveying to the complainer their disapproval of such interactions. As Kathy expressed it:

I stopped going to the cafeteria, I never go anymore on the breaks because that's when everyone bashes everybody. I just said to myself "I am not going to be a part of any of

that". I'm totally oblivious to all of this goings on – and if somebody asks me did you hear about so and so, I just say I don't know anything about that, and I don't want to know.

Shinder described tactics she took to gain support of her colleagues when she was accused one afternoon shift by another staff member of swearing at a patient. She immediately told her side of the story over the phone the same day to a trusted co-worker who was at home. This trusted co-worker, prepared in advance, went to work the following day shift and recounted the story from Shinder's side. She thus elicited support from other nurses, and discredited the staff member who made the allegations before her version could gain any credence.

Kathy, the nurse victimized in an ICU in a U.S. city, described the tactic she took to survive a targeting episode. Her tactic started by empowering herself through "self-talk" to convince herself that she was a good nurse, and then enlisting the help of a respected nurse who was not enmeshed in the ward politics - the clinical nurse specialist (a Master's prepared nurse). Here is an excerpt from that interview:

K: I eventually fought that, made a big ruckus about it, went over their heads, stood my ground and got past that and they ended up loving me. I saw that continually, as people came into that unit. They just put them through this little – I call it "initiation". You either prove yourself, or you're gone. But they were brutal to them. Backstabbing. Just terrible. It was a terrible work environment. I dreaded going to work.

A: Can you describe some tactics you used to get through that?

K: Confrontation. Exposure. I was turning into this little pinpoint of a person because I was so scared. Then I thought, "No, dammit, no". I am not going to let anyone do that to me. I am good. I am worthy. I became empowered somehow. I went and talked to the clinical nurse specialist for the unit. Now she happened to be totally out of that scene. Thank god. And I recognized that, and I went to her and talked to her. Oh, and they put me through orientation three times. Like I didn't need that, really. They were finding things. My second orientation, the girl wrote this really nasty thing about me, and it was so blown out of proportion that it was really obvious what was going on. I said to the CNS "What do you think of this?" And she said, "Kathy, I think you're being railroaded. Do you want to fight it?" and I said, "Yes I do". And she said, "It's going to take a lot of strength, you know". I said, "I know". She said "But I'll be with you, I'll be with you 100%". So I had her backing me up. That was important. So then I just started having meetings. She arranged them with the preceptor, myself, and the charge nurse. And when you put things in black and white right in front of them, it was very obvious what was going on. So I didn't have to

necessarily do anything or say anything, I just had to facilitate a place for us all to be together and then everything spoke for itself. It was exposed. And that whole team ended up kind of getting broken up for awhile.

Kathy's self empowerment included presenting herself daily on the unit as strong and not intimidated, which had the intended effect of gaining the respect from other members of the working group, including those who had initiated the targeting:

They all happened to love me because I just said "To hell with you, I don't care if you like me or not" And they kind of liked that, I guess. I wasn't intimidated. There does seem to be that little group in every place you go, it seems.

Similarly, when a manager falsely accused Shauna of administering a narcotic overdose and demanded her resignation, Shauna used immense self-control and did not panic. In order to gain time in which to analyze the situation and work out her tactics, she told the manager that she needed time to decide before she could answer. She did not become intimidated, either at that time, or later when she was being "followed" in the B ward. She was able to function competently, under very harrowing circumstances. Kathy, Susan, and Shauna demonstrated the efficacy of vigorously defending their identity as competent nurses while refusing to accept strong suggestions that they were "incompetent".

Even though Kathy and Shauna successfully survived the targeting episodes, however, they both felt marked by them, and both resigned from their respective floors or units about a year after the episodes. This illustrates, in terms of retaining nurses, the crucial importance of circumventing negative interactions before they culminate into targeting episodes.

The importance of forming alliances with other nurses on the floor is very evident in the accounts of Kathy, Shinder, Asifa, Shauna, Susan, and Iris. Having allies

appeared to be a factor that prevented negative interactions from developing into targeting episodes in the cases of Shinder, Asifa, and Iris, while having an ally helped Kathy, Shauna, and Susan work out tactics to successfully survive targeting episodes. This probably explains why “cliques” develop on the floor – nurses may consciously seek out allies to support each other from possible attacks on their identities as competent nurses. New nurses are at a special disadvantage in this respect. Shauna, for example, had not been able to form any alliances before she came under intense group surveillance. I, as a researcher doing fieldwork, however, served that function when I helped her to contact a union steward.

Renee, a nurse clinician who left Ontario due to restructuring there, used her position as a base to advocate to management on behalf of front-line nurses undergoing change and difficulties:

Some of the points that I would bring up - I think that if you are implementing change, somehow in my mind when I see this, I picture that change theory that you're frozen, you're in a period of chaos, and you're refrozen. We were in a period of chaos. They talked about supporting staff, and they kept talking about all this, that they needed to support, but all they did was try to reassure them that the outcome would be fine, and I said, "I think that you need to look at that and I think that you need to look to see what you're doing for staff during this period of chaos...reassure people about the outcome, but if you don't support them during the period of chaos, they're not going to be there at the outcome. So you need to even..go out there and you need to acknowledge, like that they're feeling upset now.

Nursing is a profession that requires empathy. Most nurses interviewed illustrated this quality when talking about co-workers. Those who had experienced targeting, displacement, or other interactional difficulties seemed especially empathetic to new nurses. As Vera said “I’m much kinder to students, now, much kinder”. Lena said, “If there is a new nurse I just want to help her - she’s afraid, you tell her ‘try this or that’ she becomes more relaxed”. Similarly, Kathy said:

So, when I precept people I make sure to show them that I don't know lots of things a lot of the time too. I just say, "You know, I don't know the answer to that, I'll go find out, though" so they know it's okay [not to know everything and to ask questions]. People just need to be recognized, they need to be supported. I just think that creates such a great work environment. Because then you just don't need to have the games, you don't need to resort to all this manipulative, horrible behaviour to try to make themselves feel good in their job.

Dina, working on an acute care floor of a smaller hospital after being displaced, thought that displaced nurses should be "buddied" with a nurse in the new receiving hospital floor:

I think when you are reassigned from a facility, I think the staff where you come into, have to be aware that this is a difficult time for these nurses, and I think people need to make a point of being friendly, and saying okay, what can we do to help you settle in and feel comfortable here? I think what they need to do is buddy you up and make sure that "is there anything we can do - do you understand the routines?"

Campbell (1992) describes a collective passive resistance by nurses to new protocols that they perceive as imposed from above and unneeded. Apparently through an unspoken consensus, the nurses in her study colluded in filling out incorrectly the daily patient classification forms - forms through which the hospital administration was attempting to quantify nursing work and patient loads by attaching numerical values to nursing tasks. Similarly, I observed nurses in acute care filling in "nursing care plans" for new patients by rote, inserting them in the required slot in the Kardex, where no one looked at them again.

The supportive actions of Pat on behalf of Asifa are similar to the passive resistance that Campbell describes. Pat is the nurse who colluded with Asifa to fill out a fictional report of how the latter was achieving "critical thinking", to be handed in to the nurse clinician. Pat and Beth were instrumental in influencing the opinions of other members of the working group to support Asifa and oppose what they presented as an

over-reaction of the nurse clinician.

The members of Susan's working group acted collectively and informally to reintegrate her into the group after a targeting episode, and to thus pull the group together again after it had become divided. Members of working groups recognize their interdependence, and the necessity of mutual support. As Mona said "we are a team, we're all here to support each other" - both as knowledge resources and socially.

Certain nurses on the floor are recognized as reliable and trusted resources to whom other nurses can bring their questions and with whom they can confirm their own knowledge about proper protocol, procedures, and medications. When a nurse has to "certify" with the nurse educator to work with central lines, other nurses may watch for their own edification, and to lend support to the one being tested. For example, they may joke with the nurse being tested, which helps her to relax, and gives a message to the nurse educator (nurse clinician) doing the testing, that this nurse has been accepted by the established nurses.

Ranjit said that at her new workplace, targeting does not happen, which she attributes to having good role models and a culture that does not permit it to happen:

We have a real bunch of role models who prevent people from going there. When I was working on [the acute care floor of the new hospital] I frequently heard the comment of nurses "I don't want to become one of those nurses that bitch about nurses". So you know, if people tried to go there, it didn't happen on the ward, because the culture really didn't permit it.

She said that when role models criticized other nurses it was done in a manner that was acceptable and receivable by these nurses, and taken as an effort to improve nursing practice rather than as a personal attack: "We have a bunch of excellent nurses who are really focused on improving practice, and criticism is not taken in a bad light.



Nobody ever wonders, 'Oh this person hates me'", she said. Ranjit observed, however, that the culture on a ward could change, and a supportive working environment could disappear with the addition or loss of a few key nurses, and added, "But each ward is different. If two or three people go on mat leave and you get two or three different people, you've got a different staff culture happening". Her observations indicate that the interactional environment of the nursing workplace is quite delicate and can be negatively or positively responsive to changes.

Social events both on and off the hospital floor are another very important means by which nurses build a "matrix of mutual support" (Rodney, 1997) among themselves. Ranjit said that an important difference in the new hospital was that the members of the working group interacted socially outside working hours:

Like they did stuff together more often. I think that makes a big difference, as staff you get to have parties and things. So they did that a bit more often, so they were a little more congenial to work with.

Of course, it is possible that in the new hospital the more congenial atmosphere and willingness to interact socially was due to better working conditions and that the "bitter" nurses Ranjit described in her previous hospital did not hold social events because of their overwork.

On another floor, Ellen said: "I work with a group that works very well together; we've started the wine club, and we do different things together". On a floor on another hospital, I saw the announcement of a meeting of a book club. In one hospital, the nurses went for breakfast together on their morning coffee breaks, while for the rest of the day, nurses brought things from home for members of the working group, such as plants from their garden, pictures of children or pets, and baking. During night shifts on

special occasions such as Christmas, potlucks were held in the nursing station. At one hospital, nurses rallied to support Pam, a colleague with four young children, who developed breast cancer and was undergoing chemotherapy. During her treatment the nurses on her floor stocked her fridge and freezer with prepared meals.

On floors where nurses do interact socially, I noticed that usually one or two nurses on the floor take on the role of social convenor – (as Mona did on one acute care floor) organizing after work events. This nurse organizes get-togethers outside the hospital such as dinner in a restaurant around Christmas time, a shower in someone's home for a nurse who has recently had a baby, or a going away party for a nurse who is leaving. On the door to the medication room or some other visible place, she puts up a small poster to announce the occasion, with columns to sign up and state what food the guest will be bringing if it is in someone's home. I saw one such poster announcing that the occasion was "A breather after Christmas".

I attended three social gatherings during my fieldwork – a baby shower, a "going away" party, and a party that was announced as "bonding time!" written above the announcement that was posted in the nursing station. The phrase demonstrated that nurses are conscious of the role that social events play in helping them to form cohesive working groups. I noticed during the social events that tensions existing on the floor disappeared for the moment. Boundaries between members of the "in-group" and those who had not yet been accepted into the in-group were not visible. Managers acted in a friendly and respectful manner to all nurses as they would act at any social event that did not originate from the hospital. Likewise, the host nurses acted as hosts, and other nurses who were guests acted towards others as fellow guests. That is,

social mores about how one acts toward guests in a social event superseded the norms that held sway on the hospital floor. The social functions present a new nurse or a nurse who may be in the prelude stage of a targeting episode in a different light than that at work. It possibly contributes to seeing her as a person, rather than just in terms of evaluating or constructing her competence or incompetence. Perhaps it establishes a different pattern of interactions, however short, that may carry on into the workplace.

"Charting time" is the most ubiquitous supportive social interaction on the hospital floor. It takes place everyday on the ward at around 2:00 pm in the afternoon, when the floor is much quieter after the noise, flurry and confusion of the morning. At this time, nurses sit together in the nursing station and write the reports about their patients in the charts. Often tea or coffee is put on, and cookies or cake brought by someone is served. From the other side of the perimeter of the nursing station, it probably looks like a party. Chairs are arranged haphazardly in front of writing surfaces: tables in the middle of the nursing station, ledges along the side. Postures are relaxed, as much of the time nurses lean back in the chairs as they chat with one another, and laugh. The mild hubbub during charting time is usually audible from the patients' rooms. At times, call bells go off (and someone might say in an annoyed manner "Oh, who's that?!), or urgent tasks must be completed, so an individual nurse walks hurriedly through the throng, followed by the voice of someone asking "Do you need help, Myra?" Usually she will say no.

If two nurses are chatting about a patient, or a problematic visitor or other professional, their voices are lowered, and nurses nearby might listen intently and join in if appropriate. This is an important aspect of mutual support – here, a nurse can

freely express her frustrations, anger, or anxiety to her colleagues about aspects of the work. From there, a united front of the nurses on the floor is often formed and presented to the patient, family, or other professional. This may start as an informal unity, and then develop into a formal one, as special "care plans" are drawn up so that all nurses will act in a consistent manner towards the problem patient and/or family so as to bring about the change in behaviour that is wanted. An example of a problem patient is one who is "manipulative", "very demanding", sexually inappropriate, or who talks in a negative manner about other nurses.

Some nurses write quickly and methodically, going through the charts at quite a fast pace, and replacing them in their racks. Others are bent over their charts more intently, writing a lot, and stopping now and then to ask how you would best describe something: for example, an abdomen that is distended and firm but not hard; or where the location of a wound or dressing is: distal? medial? This is also the time when nurses scrutinize the rotation schedule to try to arrange a trade to get a desired day off. The willingness of one nurse to trade with another so that she may have a desired day off creates a bond or obligation of the other nurse to do the same for the other.

The importance of social events like group charting sessions, and the social chitchat that accompanies the giving and receiving of change of shift reports becomes evident when reviewing the principles of social constructionism. Social interaction and influence have normative and informational functions. As Ross & Nisbett (1991; p. 44) point out, other people are among our best sources of information about the world. We attend to the views of our fellow actors because we understand that movement toward group goals depends on a degree of unanimity about our understandings of situations.

This is what Mona meant when she said "we are a team, supporting each other".

### **Formal Tactics: The Role of Unions**

In Julie White's (1993) historical account of women and unionism in Canada, she notes that women's union enrolment increased dramatically with the upsurge in the number of public sector unions in the 1960's. She notes that in Quebec, the nurses' association had lobbied for collective bargaining as early as the 1940's, and gained the right to bargain collectively in 1946, 20 years before nurses in other provinces. White considers unions are valuable for women workers, in terms of control over working conditions, protection at work (for instance, from harassment), in negotiating pay, working conditions, and benefits, in job protection, and in collective strength.

In the present study, I have described the informal actions to maintain cohesion of the working groups. So too are the formal acts, which almost always involve the union.

I start with the example of Jessie, a former head nurse who was also a union steward. Her plan to "rehabilitate a nurse in trouble" might be seen as a model. Because she was a union steward as well as a head nurse, the members of administration sometimes called on her to resolve difficult situations with nurses who were having "problems". Jessie, recounted how she helped a nurse who was "in trouble" on another floor:

As steward they called me down to talk about this nurse and what to do about her. She was making medication errors, which was atypical for her. First, we had to remove her from the unit, from the area of stress, because the other nurses were getting very antsy working with her because she was making medication errors. They [administration] said "you take her", so I took her on my floor. I offered a 6-week plan that this nurse could follow, that I had used to rehabilitate a nurse I had a problem with previously, which had worked. I called the other nurses on the floor together and said "One of your colleagues has a problem. This is a caring profession. I'm asking you to care for one of your

colleagues. I want you to welcome her, and I would be very disappointed if any of you went to coffee break and discussed this. You've got to help her".

Jessie said "I was proud of them - the only problem was that the nurses bent over backwards to help her too much!" She arranged to have a nurse that Rose liked to work with her, and Jessie met with Rose every day:

We sorted out one problem which is that Rose would get distracted when other nurses on the [previous] floor asked her to help them, and she would leave what she was doing to help them. She was trying to be all things to all people. She had to learn to say no sometimes.

The rehabilitation was successful, and the nurse is working today - "a fine nurse", Jessie says.

This former head nurse and steward consciously marshalled the cooperation of the other floor nurses and appealed to their sense of altruism and empathy in her plan to reintegrate the troubled nurse into a working group. Jessie appeared to have an understanding of the relation between social acceptance in a working group and subsequent clinical performance that drove her approach to the problem. Apparently, she managed to avoid stigmatising Rose in the eyes of the other nurses, even though she had meetings with her every day. This contrasts with the case of Shauna, who was marked for disrespect from other nurses upon being called into the offices of the manager and the nurse clinician in full view of the other nurses.

Jessie was perhaps very skilled, as a head nurse and union steward, in problem-solving and managing anxiety among members of the working group. Or, she is perhaps typical of head nurses who were immersed in the day to day working lives of nurses on a floor and were thus closely in touch with clinical issues and interpersonal issues. This contrasts with managers, who are not so in touch, as they are absent

frequently, and usually have responsibilities for other floors in the hospital, and sometimes even for floors in other hospitals. The role of the nurse clinician (who are members of the union), on the other hand, seems to be approaching that of the former head nurse, but in many cases without the immersion in the working lives of the front-line nurses, and without apparent partisanship for the front-line nurses. This may explain why the “learning plans” formulated by nurse clinicians and managers, such as the plan for Asifa to learn “critical thinking”, seemed inappropriate and out of touch to front-line nurses, and were quietly undermined by them. Jessie’s learning plan, on the other hand, appeared to “hit the nail on the head”, and served to resolve an actual problem that was mutually recognized by Rose and herself. Another distinction between Jessie and the contemporary managers, of course, is that they are acting in different circumstances – Jessie in the period near the beginning of restructuring, and the managers in the full-blown chaos and uncertainty of restructuring.

The union has been a force for solidarity among nurses. At union conventions, regional meetings, and public demonstrations that I attended and observed, solidarity between the participant nurses has been obvious. Union representatives from all over the province converge at a hotel and stay there for the duration of the convention. In the evenings, there are parties and revelry after the long (and sometimes boring) procedural matters of union business during the day. On some occasions, large emergency or special meetings are called, such as during the threatened closure of a hospital, during provincial or federal elections, or during breakdowns in contract negotiations, which large numbers of nurses who are not union representatives attend as well. Caitlin, one such nurse, said that it made her feel strong to see so many nurses

at a meeting she went to.

In the hospital, a good union steward acts as a protective buffer between the manager and front-line nurse, and as a facilitator for constructive dialogue between the two. The steward's role is also at times to assist the front-line nurse to negotiate a "competent" identity with the manager, when the manager is intent on imposing an "incompetent" identity.

The manager is obliged by the terms of her contract to "work in a collective bargaining environment", and must abide by the terms of the collective agreement between employers and employees. This includes giving stewards days off for union business, unless it is impossible due to lack of staff – a reason that is cited frequently during the nursing shortage, whereupon she sometimes may not even request replacement staff from the "staffing office". Stewards sometimes circumvent this by going directly to a casual nurse and asking her to tell staffing she is available for the shift the steward wants to get off. The manager is usually careful in her approach to the steward. Thus, there is privilege attached to the position of union steward: paid days off from the day-to-day work on the floor, and protection from potential harassment from the manager.

When the steward acts as a buffer between the front line manager and the front line nurse, the job of the steward is to determine if there is an infraction of the rules of the collective agreement, and to ensure that there is no infraction of rules during formal meetings between manager and union member. If the manager calls a union member into the office for a "disciplinary" reason (such as a warning), then she must advise the nurse to have a steward present. In the case of Shauna (Chapter 8), the manager did



not warn the union member to have a steward present during a planned disciplinary meeting, which weakened the manager's position.

It is also the job of the steward to file a grievance on behalf of a member when it is believed that the manager has violated a clause in the collective agreement. Usually the steward handling a grievance on behalf of a member is from a different floor from the griever, since it is acknowledged that if they were from the same floor it might result in strained relations between the manager and steward. The steward could possibly feel intimidated or not as effective if she had the same manager as the griever. Even though a union steward handling a grievance may not be on the same floor as the griever, she is nevertheless an important part of the interactions within the working group, and in a smaller hospital is likely to be the same person who is always called to a specific floor when there are difficulties

Some stewards are known to be fighters who will stand up for rank and file members who are in trouble with management. Others do not have such a successful record of lodging and winning grievances. Some are considered to be in collusion with management.

Not all disputes between managers and floor nurses reach the grievance stage. Often the steward acts as a mediator between manager and union member. This was evident in the case of Susan (Chapter 8), where the steward coached her on tactics to use during a targeting incident. In the following example the nurse related events to me as they happened, which I taped and transcribed, and both she and the steward took notes during and after meetings between the manager and themselves (which they allowed me to see). The following extract illustrates the buffering function of the

steward. Estelle had traded two of her night shifts with two casual nurses, so that she could extend her four days off into six days off while she was out of town. The evening before the second traded shift, the staffing office phoned one of the casual nurses to say that she was needed on another ward, not the one that Estelle worked on. The casual nurse Lara phoned Estelle's home and told her daughter that she should call in sick for her mother for the next night shift.

Steward: Where is the breach in protocol or duty here? My hope is that this does not have to go any further.

Manager: I asked Estelle to come into my office to talk about the memo I had given her about her daughter calling in sick for her. I was very relieved when she told me she did not ask her daughter to call in sick for her because it is a matter of integrity. But I am keeping the note in my office for three months, just to make sure that this is not a pattern.

Steward: But where is the breach in protocol?

Manager: I don't want to use the word breach, but the rule is you have to arrange a vacation in advance. I said that because she had 11 hours left in vacation time, one of the days could be granted. She told me that she had changed shifts with someone else for the other day. I thought it had all been resolved. I cannot pay you for that day as a vacation now, because vacations must be requested in advance.

Steward: That request is withdrawn.

Manager: I told Estelle that it [the note] will not go into her personnel file..I will keep it in my file, and if it does not happen again, it will be forgotten, it will be removed.

Steward: Your file and the Human Resources file are the same file.

Manager: No this is like writing in my daybook. If I lose my day planner, then all those details about people would not be confidential. This one is kept in a locked drawer. I tell people that I am happy if anyone wants to come to my office to see their file

Steward: My understanding is that a personal file is a personal file.

Manager: It is a totally different thing. If Estelle leaves the hospital and anyone requests a reference they phone Human Resources, they will use the file down there. This [my own notes] is not anyone's business, I use it to set course and objectives, when I wonder how it is going. This is replacing the manager's day planner. I do not put personal information into it. As far as this letter is concerned, this is documented. As far as I'm concerned this was over until Estelle phoned me, she was thinking that putting in a memo is a disturbing matter. The memo remains in my office, and vacation is not going to be paid.

Another union steward told me that according to the collective agreement, a manager is "not allowed to squirrel notes about employees in her office", other than formal performance appraisals, which are signed by the employee. In the above case, the manager apparently circumvented the rule by calling them notes in her day planner for the purpose of "formulating objectives". This was possibly a compromise, in that the union steward's demand that Estelle should have vacation time paid was withdrawn, and the memo that may have been destined for her file in Human Resources did not go there.

The steward also on occasion acts as a buffer between union members who are at odds with each other, illustrated in the case of Susan (Chapter 8). It was also pointed out by Dina - a nurse describing problems fitting into a new workplace during restructuring, who said, "There were a couple of incidents with other nurses that we had to call the union."

The steward is also a go-between for the union executives and front-line staff. She posts notices of meetings, and bulletins from the union head office. During "job actions", such as a ban on "non-nursing duties", stewards circulate around the hospital, making sure that union members are not doing "non nursing duties" or being pressured by management to do them.

As Armstrong (1993) points out, the role of the union is largely circumscribed by the terms of the collective agreement. The union may lodge a grievance on behalf of a nurse, or threaten to do so, if the manager's action can be interpreted as an infraction of the terms of the collective agreement. In the scenario described above, both the steward and the manager presented competing interpretations of the problem event,

and then negotiated an agreement so that a grievance did not have to be filed, and the front line nurse in question did not end up with a damaging note in her file at Human Resources.

The other major role of the union is to negotiate for collective agreements between the employers' association and the members of the union every three years. If talks break down or agreement cannot be reached, then the union can call for job actions up to and including a strike. In the era of restructuring, the union has played a prominent role in defending the interests of its members through collective bargaining and grievances, and has promoted solidarity between nurses, and between nurses and other health care workers (BCNU, 2002). New provincial legislation (discussed later), however, has recently restricted the role of unions. A brief history of the union follows, as outlined in a BCNU booklet published for new union stewards (BCNU, 2002).

The BCNU was formed in 1981 as the culmination of a movement for unionization among nurses that started in the 1940's. In 1943 the RNABC established a committee to investigate the benefits of unionization for nurses, but in the following year at its annual convention defeated a motion endorsing collective bargaining. In 1945, nurses at Vancouver General Hospital then joined the Nurses and Professional Workers' Union Local of the Hospital Employees' Federal Union. In the following year the RNABC reversed its position on collective bargaining and began organizing at St. Paul's Hospital, while nurses in other parts of the Lower Mainland formed the Metropolitan Nurses' Association.

Over the next ten years, the RNABC became the certified bargaining agent for most hospital and community nurses, bargaining separately for a contract in each local.

Nurses' salaries (that had been very low) doubled, 4-week annual vacations became standard, and working hours were reduced. In 1957, when employers began to reject conciliators' recommendations, the RNABC Board acknowledged the possibility of strikes as a tactic for collective bargaining. In the same year, over 90% of the nurses at Royal Columbian Hospital in New Westminster voted in favour of strike action, which was averted by a last minute settlement. In 1959, nurses at eight hospitals in the Lower Mainland voted to strike, and again strike action was averted by the Provincial Government, which agreed to provide more funds in order to meet the terms of the collective agreement. In that year, province-wide bargaining resulted in a two-year contract that included increased salary scales, a medical care plan and a pension plan.

In 1973, a development in Saskatchewan set the stage for a nurses' union separate from the regulatory body. In that year, the Supreme Court of Canada ruled that the Saskatchewan Registered Nurses' Association was "company dominated" because it was dominated by management nurses and therefore should not be the nurses' bargaining agent. The Saskatchewan Union of Nurses (SUN) was formed.

In 1977, the Labour Relations Division of the RNABC was formed as a separate and autonomous division within that body. In 1981, the BCNU was formed at a special convention of the RNABC Labour Relations Division. The newly formed union led the first strike at a facility in long term care, that won equal wages for graduate (working nurses who have not yet written the RNABC examinations) and registered nurses. Also in that year, the National Federation of Nurses' Unions formed.

In 1983, the BCNU negotiated the first province-wide Master Collective Agreement. In that same year, BCNU participated in organizing Operation Solidarity – a

movement of workers protesting unfavorable labour legislation in the province. A nurses' strike in 1984 resulted in equal wages for nurses in different long term care facilities in Victoria. In 1989 over 94% of hospital nurses voted to strike and began job actions and escalating strikes at 69 locations. The strike was ended through binding arbitration, which awarded a 21% increase in wage rates over two years. In 1990 a five-week Public Service strike, in which provincially employed nurses participated, resulted in bringing the wage rates of these nurses in line with hospital nurses. In 1993, hospital nurses ratified the Health Care Accord, which ensured job security during the ensuing restructuring that began with the closure of a major teaching hospital. In 1996, the BCNU along with other health care unions led "massive mobilization" of members of unions and the public to protest reduced transfer payments from the federal government to the provincial governments for health care. Also in that year, the BCNU retained "bumping rights" (layoffs on the basis of least seniority) through a suit in the BC Court of Appeal. The union also gained some job security for casual nurses.

In 1998, the BCNU led another strike, not only to secure wage rates on parity with other professions and occupations with comparable training levels and skill, but also to protest increasing workloads by nurses. In 2001, the BCNU membership voted over 90% in favour of strike action, and were in a legal position to strike, when they were prevented from doing so by court orders based on Bill 29 – the restrictive government legislation passed in January, 2001, which is discussed next.

Bill 29, the "Health and social services delivery improvement act" (Province of British Columbia, 2001) was passed after an all-night sitting of the Legislature on January 2001. According to the legislation:

This Bill would enable health employers and social service agencies to deliver cost effective and improved services to the public by facilitating implementation of new health authorities and social service restructuring, permitting more flexible work arrangements, removing excessive layoff and bumping provisions, and enabling improved service delivery through open tendering (Province of British Columbia, 2001).

Some of the provisions of this bill include:

The labour relations board may on application or must on direction by the minister charged with the administration of the Code, after the investigation considered necessary or advisable, consider whether continuation of a certification issued to a trade union is appropriate (Province of British Columbia, 2001).

In making a determination...the labour relations board must cancel a certification if the cancellation will (a) improve industrial stability, (b) enhance operational efficiency of health sector employers, (c) enhance a health sector employer's ability to restructure or reorganize its services or functions, (d) enhance a health sector employer's ability to integrate services or functions (Province of British Columbia, 2001).

A collective agreement between HEABC and a trade union representing employees in the health sector must not contain a provision that in any manner restricts, limits or regulates the right of a health sector employer to contract outside of the collective agreement for the provision of non-clinical services (Province of British Columbia, 2001).

For the period ending December 31, 2005, a collective agreement must not contain a provision that restricts or limits a health sector employer from laying off an employee (Province of British Columbia, 2001).

In 2001, by referring to this Act, the government stated that nurses could not refuse to work overtime. They made all collective action led by the union illegal – even the right to resign. The Act ushered in a new era in labour relations in the province. Before the passage of Bill 29, the political climate in B.C. acknowledged unionization and the rules and process of collective bargaining. Collective bargaining had been the taken for granted mode of determining wage rates and benefits in health care– that is, in determining what proportion of provincial funds should be spent on wages. This has changed. Regional health authorities are now allocated finite budgets, and rewarded for keeping within those budgets by paring down wages. To accomplish this, they have access to court orders restraining or preventing any union activity that opposes these policies. The rules of collective bargaining have thus been unilaterally discarded.

Some nurses I talked to, who did not have positions in the union, expressed indignation at the legislated loss of their rights as union members, while others did not express any opinion. All nurses who had positions in the union were indignant. Having the right to withhold or threaten to withhold their labour power through organized strikes has given nurses, up to now, a sense of their own strength and a sense of dignity. Collective bargaining on behalf of nurses has given the union its main "raison d'être". Now that this legal avenue of negotiation has been severely truncated, it remains to be seen what form nurses' resistance and solidarity will take in the future<sup>11</sup>. It is quite possible that nurses in B.C. may resort to illegal or "wildcat strikes", as described by Coulter (1993) and White (1990) in other provinces.

Coulter (1993) interviewed officials of United Nurses of Alberta (UNA) and reviewed UNA literature in her study of a 1988 "illegal" strike by nurses in Alberta. Among other conclusions, she states that this strike further strengthened a sense of solidarity and a union consciousness among Albertan nurses whom she characterizes as "the most militant members of an occupation that is increasingly becoming militant over the past decade" (Coulter, 1993; p.44). She credits the militancy to a union

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<sup>11</sup> In Ontario, a formal organisation has been formed to defend nurses against racism - the Coalition for Black Nurses and the organisation of Nurses and Friends Against Discrimination (NAFAD) formed in Ontario in 1991 and 1992 respectively (Calliste; 1996). These organisations held the conferences that Calliste attended during part of her data collection. She advocates organizing on the basis of antiracism theory, which focuses on racial identity and consciousness as a community organising tool. Calliste advocates that Black communities build their own institutions, and strive for self-determination. Similarly, Hemmons (1996), another Black feminist writer, does not advocate separate institutions, but does advocate the development of strategies to increase the level of political functioning of the masses of African American women through group unity, grass-roots organizing, and community mobilization.

In Vancouver, the Filipino Nurses Support Group (FNSG) is a formal organization that has agitated for some years for the release of nurses working in the Live-in Caregiver Program and for their right to practice the profession of nursing as equals to other nurses in B.C. Philomina, a member of the FNSG explains that her group argues, demonstrates, and organizes petitions against the ghettoization of Philippina nurses in the LCP, whom they consider are being held as a surplus cheap labour supply for the



leadership that has fostered grass-roots involvement, and that has challenged the “master-slave mentality” of the employers by refusing to accept “roll-backs”, concessions, or any form of arbitration.

Jerry White (1990) similarly identifies feelings of solidarity among interviewees in his study of a 10-day “wildcat” (illegal) strike by 10,000 hospital employees in Ontario in 1981. Many of these non-professional workers, who were predominantly women, expressed satisfaction and feelings of having maintained their integrity through their actions, despite some costs in the form of punitive actions by employers.

In addition to collective bargaining, the BCNU has participated in broader based actions involving other unions and members of communities. These actions have included campaigns to oppose restructuring, privatisation, and contracting out of health care services. The BCNU has also been promoting the theme that unions and “grass roots organizations” should be allowed to participate in restructuring decisions, and that nurses’ workloads have become too heavy and onerous with the restructuring initiatives.

In an article titled “Health care restructuring: Which direction for ‘New Directions’?” (BCNU, 1993), the authors decry the lack of opportunity for participation by health care unions, community organizations, women’s groups, “and other grassroots organizations” in the planning and eventual execution of a proposed regionalization plan. An accompanying cartoon shows a man dressed in hospital pyjamas lying on the ground with groups of dark-suited men (and a few women) pulling

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privatized health care companies of the future.

off both legs and one arm of the patient, while a group of white-capped nurses try frantically to sew the other arm back on.

In a 1994 issue of *Update* (BCNU, 1994a), the authors identify "management-sponsored employee involvement programs" - such as Total Quality Management, Shared Governance, Patient-Focused Care, Continuous Quality Improvement - as an outgrowth, in Canada, of the "Theory Y" management tactics developed in the United States over 30 years ago. These management tactics, they state, start out "honestly enough" by seeking input from nurses and other employees about their working conditions, but end up with "unilateral" decisions to cut jobs and increase workloads, that result in decreased quality of care for the patients. An issue of *Update* in the same year (BCNU, 1994b; p.3) begins with an address from the union president titled "The truth behind Patient Focused Care". In this article, she equates Patient Focused Care (PFC) with Budget Focused Care, or Profit Focused Care, and states that the result of such management programs has been to reduce drastically - sometimes by as much as 50%- the number of RNs in a facility and replace them with " 'cross-skilled', unlicensed, unregulated, low paid persons with minimal training and education". These practices, she states, are reducing the practice of nursing to functions and tasks, which along with the loss of nurses, places the patients at risk. Reduction in the quality of patient care, resulting in "near misses" and actual harm to patients, she states, is well documented by the California Nurses Association and the Staff Nurses in Alberta in facilities where PFC has been initiated.

The front cover of a 1998 issue of *Update: The British Columbia Nurses' Union Magazine* (BCNU, 1998) shows a photograph of a middle-aged nurse wearing an

isolation gown, adding medications to a bag of intravenous fluid, with the caption "Working Too Hard" underneath it. The lead article in this issue states, "workload results [that is, the results of an opinion poll conducted by the union among its members] confirm bargaining goals" (BCNU, 1998; p.3). Other articles state that as a result of the impact of health care changes, nurses are burning themselves out maintaining quality patient care in the face of a rapidly increasing workload (BCNU, 1998; p.7; p.11).

While a large number of nurses do not take an active part in union activity except when called upon to vote for and take part in job actions during collective negotiations with the employers, the union has nevertheless served as a unifying force among all front-line nurses, and a vehicle for collective action for them. It appears to have helped to attenuate some negative repercussions of restructuring on the working environments of nurses, and to have helped to protect the integrity of the institution of public health care by delaying or even preventing some aspects of privatisation of health care services.

## **PART FOUR: CONCLUSION**

### **Chapter 10: Discussion, Implications for Policy Changes & Future Research**

#### **Initial Concluding Comments**

This study is an exploration of the working environments of hospital nurses during the implementation of vast changes in the health care system, known as "restructuring". The B.C. Provincial government, along with other provincial and territorial governments, pointed to the decreased transfer payments from the federal government in the mid 1990's as a reason for the need to restructure the health care system. In B.C., 52 regional health boards have been amalgamated into a smaller number of Health Authorities. Within health regions, some hospitals and programs have been closed or cancelled while others have been amalgamated. "Public/private partnerships" have emerged, allegedly because the health care system is not "sustainable" or "viable" without them. Management models borrowed from the business sector have been introduced into health care with the stated aim of efficiency.

Models of management like TQM and Patient Focussed Care were borrowed from the business world and introduced into hospitals in the early 1990's in the form of Total Quality Management and subsequent forms like Patient Focused Care. Head nurses on nursing wards were replaced by "managers", whose responsibilities expanded to cover multiple floors and units, and whose responsibilities included, for the first time, budgets. "Accountability" of the nurse (previously to the patient, public and profession) acquired a new meaning - that of accountability to a budget. Concurrently,

many nurses perceive the attribute of "altruism" to have disappeared from hospital nursing, which calls into question the status of hospital nursing as a profession<sup>12</sup>. Hospital nursing has also begun to take on the characteristics of "lower echelon jobs", discussed in the following section, which also calls into question its status as a profession.

The closure of a major teaching hospital in Vancouver in 1993 marked a most ominous beginning to restructuring of the health care system, in the minds of its staff and of health care workers throughout the province. Narratives of nurses who had worked at this hospital and had then been relocated to other hospitals throughout the Lower Mainland illustrated feelings of being buffeted about by forces beyond their control. Many suffered physical and emotional health problems during and after the relocation process. Continuing uncertainty and ongoing changes over which they had no control faced these nurses as well as nurses in other hospitals. Ethical dilemmas exacerbated by restructuring also caused distress.

Formal and informal practices of inclusion and solidarity among nurses have been an important antidote to distress. While organized resistance in the form of strikes had previously been an effective tool that showed the collective strength of nurses, strengthened their self-respect, and allowed practices of inclusion among nurses, the government and health employers have deliberately weakened this tool, beginning with legislation like Bill 29. This government legislation set the precedent whereby the Health Employers' Association can apply to the courts to declare any collective action by

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<sup>12</sup> "Altruism" is one of the defining characteristics of professions demarcating them from occupations, according to nursing texts that cite Abraham Flexner's criteria for professions in his 1915 study "Is social work a profession?" (for example, Creasia & Parker, 1996; Potter & Perry, 1993).

nurses, led by their union, to be illegal. It is possible that in the future, nurses may resort to non-sanctioned tactics such as calling in sick more frequently, or "wildcat strikes" as described by Coulter (1993) and White (1990).

Tensions on nursing floors often result in dysfunctional and harmful patterns of interaction among members of the nursing working groups. Tensions among nurses are due to the nursing shortage, uncertainty about the future of hospitals and the future of the nursing profession itself, changing domains of responsibility (for example, changing mandates of nursing managers), changing levels of acuity of patients (patients are sicker), inadequate orientation to nursing floors for new nurses, lack of senior nurses to provide mentoring roles for other nurses on the floor, worries about competence, ethical dilemmas, and lack of control by front-line nurses over their working conditions. All these factors relate to the context of "restructuring".

Tensions appear to be most acute on acute care floors. As discussed previously, patient acuity has risen most dramatically on these floors, yet staffing levels have remained the same, or have dropped, due to the nursing shortage and hospital budgetary policies. Moreover, nurses are expected to cope with the higher acuity and with new procedures, but they do not have the additional training that nurses have in critical care that makes the latter more confident in their own competence to cope with unexpected clinical events that may arise. Ethical "dilemmas" abound on acute care floors especially, with ambiguities in the "code status" of patients, and other matters having to do with advanced technologies. These are "dilemmas" in the framework of the health care system as a whole, but for front-line nurses they do not present as difficult choices to be made, but rather as unpleasant tasks they must perform regardless of

their personal beliefs.

Thus, not unexpectedly, in this study, it is on acute care floors that dysfunctional patterns of interaction are most likely to culminate in targeting or workplace bullying – or what I have referred to as “anxious competence” and “projection of incompetence on the other”. Targeting or the fear of targeting discourages many nurses from applying to transfer to highly acute care floors from extended care floors, or sub acute floors. Since experience on acute care floors is the prerequisite to working in critical care levels or in other specialties, acute care floors thus serve a gate-keeping function between the levels.

Part Two of the study consisted of ethnographic descriptions of the nursing working group and its members, the physical environment of the workplaces, and the nature of hospital nursing work. These descriptions led inexorably to a consideration of hierarchy and class differences in hospitals. Hierarchy and class differences in hospitals are signalled by physical markers such as uniforms worn by nurses in acute and extended levels of care, and by the different types of technology used during work. Uniforms demarcate nurses from members of other professions in the hospital, who do not wear uniforms, and indicate differences in the type of work.

Characteristics of work symbolized by uniforms include physical contact with patients and patient secretions, carrying dirty laundry, and other aspects of lower level service-oriented work. This contrasts with the former meaning of uniforms when the profession of nursing was young, when uniforms were crisp, white, and denoted asepsis and moral authority of the nurse. Hospital nurses are now seen to be “at the beck and call” of patients which is not true for the other professions. Their work is also

often stigmatised as “dirty”, symbolized by both uniforms and artefacts like the bedpan.

The use of technologies marks and supports hierarchical and class differences in the hospital. Certain technologies denote higher prestige and status than others. While the “hands on” physical work of nurses with patients is not very valued, invasive technologies used by physicians to probe the inside organs and arterial and venous pathways of the patients is highly valued and respected. Nurses who work in levels of care where invasive technologies are used, and who carry out physician-delegated duties using some aspect of the technology (for example, cardiac outputs using the Swan Gantz catheter) gain respect and prestige through their association with it and with the medical profession. The use of equally complicated technologies such as the pneumatic lift used in extended and sub acute areas to lift patients out of bed do not accrue respect and prestige for the nurses using them.

While the overall lower position of nurses in the hospital hierarchy in the study is associated with the gender identity of the nursing profession, and the proletarianized nature of their work, hierarchical differences within the occupation of hospital nursing itself are associated with level of nursing and racialized ethnicity. This is most salient in this study when observing the different demographic makeup of the different levels of care, with critical care units in a large teaching hospital mostly occupied by white nurses of Anglo or European origin, while a disproportionate number of nurses of colour, whose origins are from formerly colonised countries, work in extended care and sub acute floors. The reasons for this are multi-factorial, as discussed in Chapter 5, and are analysed in greater depth later in this chapter. Ageism is also implicated – work with elderly patients and sub acute patients is stigmatised, as are older nurses who work in



these areas. Nurses in critical care units have higher prestige and also relative privilege compared to those working in the other levels of care in terms of lightness of work (not having to transfer and position heavy patients as much), being responsible for a lower number of patients, not having to walk long distances up and down hallways during their shifts, and not being "at the beck and call" of the patients (who are often unconscious and/or ventilated) or their families. On some extended care floors, nurses maintain the relative privilege of not having to wash and dress patients/residents, leaving this work to the PCA's.

### **Degradation of Work**

Hospital nursing work as a whole is increasingly taking on characteristics of lower echelon jobs. This process has accompanied restructuring. Conceptual work is increasingly divided from physical work, which corroborates Braverman's thesis (1974) published 30 years ago about the degradation of work in the 20<sup>th</sup> century. Hospital nursing work has become more routinized, with less conceptualisation taking place during an average working day. Decisions are most often rule-based rather than based on a specialized body of knowledge. This presumably makes it easier for administrators to replace registered nurses with lesser-qualified health care workers, such as licensed practical nurses, which is taking place on numerous hospital floors, especially those with lower acuity.

Categories of nurses responsible for conceptual work are being differentiated from those who do mainly physical work. A new class of managers and "educators" have taken on the job of planning and conceptualisation of patient care on many floors, while front-line nurses are increasingly consigned to carrying out tasks without

reference to an overall plan or theory. In extended and sub acute care levels, LPN's with almost the same "scope of practice" of RNs have begun to replace or work alongside RNs – a phenomenon erroneously referred to as "skill mix".

A hierarchy of greater to lesser degrees of conceptualisation on the job characterizes nursing work, with critical care having the highest level, and extended care the lowest level. One interviewee observed that front-line nurses in critical care were interested in research, read articles about nursing research and actually implemented the findings of some studies in their nursing practice. In wards on other levels of care, only the nurse clinician or educator would be likely to read research articles and apply the results.

Opportunity for conceptualisation includes the opportunity for autonomous decision-making while carrying out the "nursing process", which consists of assessment, planning, implementation, and evaluation. Front-line nurses as a whole do not have the same opportunity as managers and nurse clinicians in this respect. In the quest for self-fulfilment, some front-line nurses apply for the positions of manager or educator. Ascending the hierarchy might be seen as itself a goal that would lead to self-fulfilment. Ascending the hierarchy could thus be a substitution of sorts for the lack of self-fulfilment. Front-line nurses on some floors experiencing a nursing shortage worked extremely hard and took pride in being able to care for a larger than average number of patients. In this case, too, working hard appeared to be a substitute for self-fulfilment - a challenge to their capabilities. This phenomenon is perhaps similar to the "game-playing" identified by Buroway (1979) among machinists.

It is clear many interviewees consider that front-line nursing does not give scope

for the full development of their mental capabilities. This is in line with the Marxist conception that attention to detail is taking the place of exercising one's will during the labour process. The dissatisfied ICU nurse who took on the challenge of creating a new work schedule is one example, as are the former head nurses and managers who took on the position "because I knew I could do it" or "I knew I could do more than that", and the manager who became a manager so that she would have more decision-making power. The attraction of working in the ICU, without extra pay, is also testament to the desire of some nurses to have more challenge, decision-making power, as well as more prestige. In acute care, not only is decision-making more curtailed, but also the physical work is more arduous and takes its toll physically on nurses. Most do not stay there past their 20's or 30's. Many nurses consider their stint in adult acute care as a stepping-stone to a specialty, such as critical care, neonatal care, or obstetrics.

Along with decreasing opportunities for conceptualisation, increased routinization and intensification of work and decreasing control over the labour process also mark nursing work in the era of restructuring. In Chapter 6, "Narratives of Restructuring and Ethical Dilemmas" – lack of control was the theme that was most evident and caused the most distress among nurses.

### **Self Esteem in Jeopardy**

In Part Three, the focus was on interactions within the nursing working groups, and the problematics of the interactions there – or what is popularly known as "politics". Problematic interactions are epitomized by the phenomenon of targeting - or as I have called it, "anxious competence" and "projection of incompetence on others".

During and following a targeting episode, the self-esteem of the victim of

targeting is in jeopardy, as well as her physical health. She becomes stigmatised through the targeting episode. Because of the negotiative aspect of making meanings during interactions on the floor, she may become convinced at some point that she truly is to blame for the targeting and is an inferior nurse. The conditions for her targeting, on the other hand, are related to the fact that the self-esteem of all the members of the working group is in jeopardy. The lowered respect and prestige for the profession of nursing that front-line nurses perceive impacts on the self-esteem and self-respect of nurses themselves.

Nurses who might potentially lower the already lowered prestige of nursing or of a nursing floor are perceived as a threat to the self esteem of other members of the working group. As well as constant vigilance about appearing competent, they are also vigilant for "non-professional" behaviour in other nurses, such as loud talk, or the casual attire of some younger newer nurses. The background of a new nurse – where she worked before - may detract from her perceived ability or potential to fortify respect for the floor. Besides self esteem, the reputation of the floor is important for the future prospects of other nurses on the floor, who may have plans to transfer to other areas or levels of care in the hospital. It is possible that competition for more desirable positions in the hospital may also play a role in targeting episodes.

In the opinion of some interviewees, the profession of hospital nursing appears to have lost ground, in terms of respect and prestige, as other professions have opened up to women. Some interviewees said that they tell their daughters and other young women, "don't go into nursing". As one nurse said "there are so many other things that women can go into nowadays" such as speech therapy, physiotherapy, and

pharmaceutical marketing. This nurse considers that due to more choice of professions, newer nurses are not of the same calibre as nurses 20 or 30 years ago. The reluctance of newer nurses to wear uniforms possibly reflects their perception that nursing as a profession lacks the same respect as other professions in the hospital whose members do not wear uniforms.

The perception of hospital nurses that there is less respect for their profession, in turn, has implications for stratification within hospital nursing itself. It strengthens the motivation of some nurses to go into areas of nursing where it is perceived that nurses have more prestige or respect, such as critical care, even though the rates of pay are the same, and more training is required to go into those areas (often at the nurses' own expense). As one nurse stated: "ICU is more sexy than acute care" in terms of the respect of doctors for nurses, and for nurses' respect for themselves. It also appears to offer more of a challenge. Thus nurses apply or transfer to acute care areas with the aim of eventually working in other areas, and are willing to pay the price, which sometimes includes a difficult re-socialization period that may even result in targeting.

Even in critical care, however, it appears that nursing work in itself is not enough for self-actualisation. Nurses who have been working in an ICU setting for many years find that they must resort to other means to find self fulfilment, once they have mastered proficiency at this level of care. Most nurses in critical care were said to be "all doing other things - not just nursing or family. In addition to meeting the need for self-fulfilment through outside pursuits, these activities also helped to elevate the status of critical care nurses. By letting it be known that they were seriously involved in pursuits not associated with the roles of mother and nurse, critical care nurses gained

more recognition and respect, both for themselves and for the critical care area as a whole.

The perceived lack of status of acute and extended care levels, compared to that of critical care, has implications for the dynamics on the ward. Acute care nurses working on wards with higher acuity consider themselves more competent than those working in less acute wards, and are considered as such by those in the less acute wards. The prevailing emphasis and preoccupation with competence seems to inform nurses to think of themselves largely in those terms. Nurses working on less acute wards or in extended care appear to be thought of as being "not up to par", though this must never be mentioned out-loud. In order to transcend the category of "not as competent" some nurses and managers on the latter wards are very strict with themselves and others about details that might seem relatively minor in other settings, as illustrated in the narratives by Jane about the tube feed in ECU, and by Shauna about her experiences on the "B" ward.

### **The Targeted Nurse**

On an acute care floor during the present time of budgetary restraints, the orientation period for a new nurse is very short – sometimes just two days or so, and this has implications for targeting. In previous times, a new nurse might have spent up to 2 weeks getting to know the ward and the other nurses, during which time she would not have been expected to function on her own on the ward. Her presence would mean the nurse she was buddying with would have two weeks with a much lighter load than usual. This is not the case nowadays. Acute care nurses do not have the time or inclination to supervise new nurses on the ward when it would mean increasing, rather

than lightening, their loads. Because of the intensification of work, nurses on acute care are tired, working quickly, and worried about giving good care and not making mistakes.

Nurses new to the ward, then, must "sink or swim" in a rather tense, fast-paced atmosphere. It supposedly falls to the nurse clinician or "nurse educator" to supervise and give support to the new nurse on the ward. Nurse clinicians, however, often appear to be taking on the characteristics of a head nurse or assistant to the manager, but without the familiarity and supportive attitude of some former head nurses. Their role at times seems to be more hostile surveillance than support. They are not always seen as trusted peers.

Nurses who arrive on an acute care floor from extended care or a sub acute area undergo a period of intense surveillance that is often perceived as unfriendly. The initial period of intense surveillance may develop into a targeting episode if certain conditions are present on the ward, and is more likely if the new nurse shows lack of confidence and nervousness, or on the other hand overconfidence; if she flouts norms, such as appearing to disregard consensus among some more senior nurses; if she is not able to quickly make allies and friends among other nurses in the working group; or if she is somehow "different". New nurses who are "anxious performers" are less likely to survive a targeting episode than those who are more implacable, or who have extensive related experience elsewhere.

The presence of a relatively larger number of "new grads" on acute care floors contributes to the frequent atmosphere of anxiety on the floor. They do not have the long experience that gives confidence to older veterans of nursing, nor do they have the latter as long-term mentors. They are unsure of themselves and of others. Their

preoccupation with "competence" in an intensified working environment, combined with dire warnings of legal consequences during their training, sometimes results in a kind of paranoia capable of escalating to a full scale targeting incident that is a projection of a collective fear of incompetence.

As well as short orientation periods for new nurses, other conditions on acute care floors that could help to generate targeting episodes include understaffing; an increase in acuity; no opportunity for peer consultation about nursing practice; lack of educational and emotional support for nurses on the floor; a recent history of a serious medication error on the floor, or some other "close call"; a manager who has "too much on her plate" to keep close tabs on what is going on in the ward; a manager who is not able or willing to circumvent a targeting episode.

Like the "long arm of the law", the spectre of targeting seems always present in nurses' consciousness, causing anxiety about the possibility of making mistakes, and hesitation to do things differently than the norm. Most nurses are hesitant to transfer to other more acute floors where they would have to face re-socialization and the possible danger of targeting. It is thus a form of social control on the ward, though not a conscious one.

Targeting is injurious to the targeted nurse, who shows symptoms of emotional and physical pain and illness. Other nurses on the floor, whether or not they have taken an active part in the targeting, suffer anxiety and discomfort also. Even when targeted nurses are reintegrated into the working group after a temporary expulsion, their outlook on nursing may have changed and they may end up leaving the ward on their own as soon as they have the opportunity.



The former head nurse, in Chapter 9, who described the “rehabilitation” of a nurse having “troubles” could serve as a model for how to support the orientation of new nurses, or the reintegration of targeted nurses back into a workgroup. This former head nurse had been a union steward as well as a head nurse. She identified her family background in the UK as “labour” and was as firmly committed to the well being of her nurses as she was to the patients on her ward. Her plan of rehabilitation started by bringing the other nurses on the floor “on side”, before the new nurse was introduced, and gaining their cooperation and assurances of confidentiality. Jessie appealed to their senses of altruism and collegiality by saying, “one of your colleagues is in trouble and I want you to help her”. She did not court nor tolerate gossip or “tattling”. In her interviews with the nurse, Jessie was able to pinpoint some specific problems such as her inability to say “no” to requests from other nurses to leave her work and go to help them.

This contrasts with the experience of Shauna, in Chapter 8, who was called into the offices of the manager and the nurse clinician – in full view of the other nurses – and made to fill out “learning plans” that she perceived had little to do with what she really needed to learn. In the former case, Rose found the advice useful and was able to integrate into the new working group to the point that Jessie considered that she became “a fine nurse”. In the latter case, Shauna perceived the calls into the offices as rites of humiliation, and although she said that she “loved to learn”, she did not find these sessions useful. She also perceived that her colleagues did not respect her. Her perception supports Ross & Nisbett’s (1991, p.12) view, that “many well-intentioned, even well-conceived, social interventions fail because of the way in which they are construed by the targeted group (for example, as an insulting and stigmatising

exercise)". The enforced office meetings were a factor in the social construction of Shauna as a deficient nurse, much like the visits of a caseworker pointed out by Ross and Nisbett (1991):

The act of intervening implies the need for such intervention. The visit of a caseworker suggests that there is some deficiency to be remedied; it tells the world that negative outcomes are occurring and perhaps can be expected to occur in the future. Such a message can label or stigmatise the recipient of assistance in a way that changes the behaviour of other people (p.216).

Informal organization of solidarity among nurses was important for aborting a targeting episode before it got to threatening proportions, as shown by the actions of Beth, in Chapter 9. She rallied opinion on a floor adjacent to another floor where it seemed that the singling out of a nurse by the nurse clinician might snowball into a full blown targeting episode. She rallied opinion by pointing out how unreasonable and unimportant the issue was that the nurse clinician was making "a big to do" about. The nurse clinician was no doubt sensitive to the opinions of the nurses on the other floor which was considered "a high functioning" one, with higher acuity than on her floor. Another condition that probably supported Beth's actions was the relative lack of tension on both floors at the time: there had been no recent history of serious medication errors; the floors were not excessively busy; there were no current changes or upheavals.

In considering measures to prevent or abort targeting incidents, then, it is useful to consider whether or not conditions causing tension on the floors is present and to what degree. If things were very tense, this would merit special attention and perhaps having "time out" seminar sessions among the nursing staff, chaired by a neutral third party, to vent feelings and examine recent interactions in a safe and non-threatening

context. Such seminars should include everyone on the floor, and not develop into a forum which some staff could use as a stage to launch a campaign (conscious or not) through innuendoes against an excluded other staff member: One thinks of the floor meeting described in Chapter 8, in which the manager said that several nurses asked her, in the context of worries about Susan's competence, "what would happen if another nurse makes a mistake, would they be responsible?"

The fact that most targeting incidents I witnessed or heard about took place in acute care rather than in the other levels of care, supports my contention that while targeting on hospital nursing floors shares characteristics with mobbing, bullying, and targeting described by many authors, it also has important differences. These differences have to do with a genuine and anxious concern about standards of nursing practice, and the fear of incompetence, both within the nursing work group, and within the individual nurse herself. This anxiety is exacerbated by the nursing shortage and by hospital restructuring.

At the same time that targeting in hospital nursing differs from targeting and mobbing described in the literature, it also shares many characteristics. It generates and reflects acute anxiety on the floor, and has adverse health effects. Since the scope of previous studies about targeting and mobbing have not included all-sided explorations of the factors involved in the incidents, it is not possible to determine whether or not they all share parallel causations and trajectories. If they do, then one could consider they are, in fact, the same phenomenon but look slightly different in appearances. If they do not, then they are different phenomena. This is a possible fruitful avenue of future research.

One of my objections to the terms "mobbing" is the implication of a large group of individuals ganging up on an individual, which is not the scenario found in the present study. It is usually only one or two, or at most a small number, of nurses who instigate a targeting episode, while the majority of the other nurses are either passive bystanders or are not aware of the episode. The term "mobbing" does not take into account the generalized anxiety or terror experienced by all involved. Lemert's seminal study was the only one encountered that did describe and take into account the generalized feelings of anxiety, but again, the context was a group against an individual. The larger context of the workplace and possible causative effects to be investigated within it are overlooked or ignored. "Bullying" also is not an appropriate term for the process of targeting because it implies malice and intent to harm, which was not found for the most part in this study. Rather, the anxiety around the competence of self and others appeared to be the main motivating factor. Targeting in the nursing working group, therefore, is better thought of as "anxious projection of incompetence on the other".

In the mobbing literature reviewed, the lengthiest case study was of a manager who tried to institute changes to a resistant staff, the members of whom ganged up on her, and forced her removal. I did not witness or hear of a similar case in a hospital. I was aware of five managers who lost their jobs (one in acute care, three in extended care, and one in critical care). Four were quite popular with their staff, and had been removed on short notice from somewhere "higher up". In one case, the staff had even rallied to the manager's support and demanded her reinstatement (It is relevant to note that this took place in a critical care area). Another less popular manager (in extended care) was removed to another location after about ten years in the position. I was told

that those years were marked by “a stack of grievances this high” representing continuous discontent among her staff caused by “picking on people”, being intrusive, and being unfair. Since the higher administration received numerous complaints about this manager from staff members, and she was eventually removed, it seems that this manager did not find the right balance between maintaining her authority and placating the in-group. This contrasts with Manager C. (on an acute care floor), discussed in Chapter 5, who maintained control over members of the “in-group” while at the same time garnering their support. Garnering support, however, meant that this same manager felt compelled to take an active part in a targeting episode as it gained momentum (described in Chapter 8), rather than trying to defuse it. From her perspective, being able to fire the nurse in question would have been the quickest tactic to restore calm to the nursing working group. This was a double-edged sword, in that it had a negative effect on her health, too, as well as that of the other nurses who had witnessed or taken part in the targeting episode.

### **The Social Construction of “Competence” and “Incompetence”**

Like the construct of “skill” (Rauch, 1996), the entity of competence is not easy to measure, define, or describe. Comprehensive definitions of competence and published guidelines to achieve and evaluate competence are available to front-line nurses, nurse clinicians, and front-line nurses themselves, through nursing publications that have been readily available on the floors, as well as posted on websites. Nevertheless, a common understanding of what “competence” is, continues to elude most members of the nursing working group during their day to day work and interactions. Certain situational factors that may be present on a hospital floor at any

one time, along with changing aspects of the nursing labour process discussed above, appear to supersede or have more of an influence on the actions of nurses than any understanding of the term of competence that may have been gained from having read the specific guidelines or definitions previously.

“Competence” among nurses in hospital settings is a socially constructed entity that is negotiated among members of the nursing working group on a day-to-day basis. It is not a neutral entity. Several instances in the study serve to illustrate.

It is illustrated in the case of Shauna, who said that she was afraid other nurses would think she was “this incompetent nurse”, after the manager and nurse clinician demanded that she resign on the false charge that she had over-sedated a patient with a narcotic. “Incompetence” would have been implied, though not demonstrated, had she resigned. Other nurses would have thought that Shauna had shown faulty judgment and reasoning in administering the narcotic, or that she had shown flagrant disregard for (or ignorance of) the specified parameters of time for administration of the narcotic, ordered by the physician. That is, other nurses would probably have assumed that the errant nurse had violated some concrete guidelines that by definition rendered her incompetent – unfit to practice.

No such evidence, however, was marshalled. Other “evidence” that was marshalled at the time of demanding her resignation, such as not noticing an order to change the rate of IV fluid, and not administering a unit of blood because there was no one available to assist her, did not have such concrete guidelines. In those instances, other nurses at the time of those infractions would have done well to consider (and some may have done so) factors like how busy the floor was at the time, and the

experience or lack of experience of the nurse in question, in helping them to determine whether or not this constituted "incompetence". That is, they would have referred to informal "yardsticks" in the backs of their minds, that would have led them to ask questions such as: "Should the nurse have known better, given her length of experience and access to information and support?"

In the minds of nurses, the "bottom line" concerning competence and incompetence is whether or not the action or lack of action of the nurse endangered the patient's life or well being, and in the process, endangered the reputation of the floor as safe and of the nurses as capable, good nurses. Shauna, in refusing to administer blood near the end of the shift when she had no one to advise her, took a cautious route, and left it to the nurses on the next shift, knowing the dangers of possible anaphylactic reactions to blood infusions.

Similarly, Susan called a code (despite the "no code" designation on the Kardex) because she was not satisfied that the patient's family and other team members had consensus about the code status of the patient. The respective managers pilloried these two nursing decisions. The decisions were not pilloried on the bases that they endangered the lives of patients. In fact, the manager in Susan's case said that it would have been far worse if the opposite scenario had taken place - if Susan had not called a code when the patient was designated a "code". Nor did the decisions violate concrete standards of competence found in the policy manuals of the hospital. The alleged infractions were of a lesser sort.

According to the manager, Susan's infraction was that she appeared not to have read or remembered that the patient had been designated a "no code" in the Kardex;

and therefore the manager considered that she was just as likely to commit the more serious infraction in the future of not calling a code when one was ordered. The infraction was indicative of "potential incompetence". The "waste of resources" and the annoyance of the ER doctor called to the scene accentuated the seriousness of the infraction in the mind of the manager.

The specific protocol that Shauna had violated that the manager pointed out was that she did not infuse a unit of blood early enough so that a second unit of blood could be infused before the cross match expired. If the charge nurse had been aware of the problem or had time to address it, or if another nurse had been available to answer Shauna's questions and to help her to start the blood infusion on the day shift, the protocol would not have been broken. If the nurse on the next shift had taken less time to go over the change of shift report (this is a social occasion as well as a functional one) the blood may well have been infused on time. If Shauna had more experience, she could have "button holed" the charge nurse, asking her advice on what to do. She would have risked mild displeasure from this nurse, however, since it was near the end of the shift, and the charge nurse was doubtless hurrying to finish all her tasks, as were all the other nurses.

Rather than being due to a failure of judgment of individual nurses, the infractions committed in these two examples were due to the failure to confer with, or not having the opportunity to confer with, other members of the working group or team on what action to take. That failure, in turn, was related to the fast pace of work, the lack of time and opportunity for mentoring, and patterns of communication between established nurses and new nurses that had begun to alter or deteriorate. Shauna, for



example, had begun to feel inhibited or easily discouraged from asking questions from other members of the working group. Exacerbating matters, from the point of view of the budget-conscious managers, the infractions also caused resources to be wasted.

In the above examples, "incompetence" was not measured, proven, or even mentioned. Although I heard many nurses in the present study express fear that they themselves were "incompetent", or express fear of being thought of by others as "incompetent", I heard only two nurses talk about another nurse as being "incompetent". It was, rather, mostly implied. If I asked what happened to another nurse who had disappeared, the typical answer, given with obvious discomfort, was "I don't know", or "She was fired, I guess". The concept of "incompetence" appeared to be unmentionable. It was the invisible opposite of "competence" – the ubiquitous, yet equally ill-defined yardstick against which every nurse measured herself and others, often with anxiety. It was socially constructed through a specific set of interactions, against a backdrop of hospital protocols which nurses had little time to reflect upon or memorize. As Ross and Nisbett (1991) point out about the social construction of events:

People ..fail to make sufficient allowance for the role that construal plays in determining behaviour, a failure with profound personal and social consequences. The first error is a failure to recognize the degree to which one's own understanding of [an event] is the result of an active, constructive process, rather than a passive reception and registering of some external reality (p.12).

The social construction of "incompetence" illustrated in the examples above serves to individualize and simplify what is really multi-factorial. The matter was not that two nurses were found to be unsuitable for the job of nursing, through some objective set of criteria. The matter was that infractions of protocol were committed due to a

complicated set of circumstances. A comprehensive and critical examination of the circumstances surrounding each of the two incidents may have brought to light the causative effects of the actions or inactions of other team members, or members of the working groups, and other matters impinging on the actions and judgments of the two nurses. Some of those factors may or may not have been within the control of the managers and the other members of the working groups. Such critical examinations, unfortunately, are rare. Reviewing guidelines and publications concerning how to aim for and evaluate competence and apply it in the concrete circumstances of the nursing working groups may not be done frequently. This may be due to constraints of time and resources on acute care floors.

### **Factors Maintaining Job Segregation**

Job segregation is the other main contextual theme, along with restructuring, that has provided the background for the descriptions and narratives of this study. Although no official hospital policy allocates (the already gender-segregated) nurses to different areas of work on the basis of race or ethnicity, there appears to exist some sort of unofficial sorting process that accomplishes this. In the section "Racialized Ethnicity and Hierarchy" in Chapter 5, the themes of cultural differences, racial discrimination, language proficiency (or lack thereof), and different life circumstances were offered by interviewees as explanations for why nurses of colour belonging to racialized ethnic minorities are concentrated in extended and sub acute areas of hospital nursing, rather than in the other more prestigious levels of care. These themes are examined in more depth in this section.

Nurses as "bearers of culture" and possible transmitters of essentialized and

marginalizing notions of culture were problematized by a team of researchers (Kirkham, Smye, Tang, Anderson, Blue, Browne, Coles, Dyck, Henderson, Lynam, Perry, Semeniuk, and Shapera, 2002; p.223) who were preparing for fieldwork to study the hospitalisation and help-seeking experiences of "diverse ethnocultural populations". While racism, stereotypes about racialized ethnic minorities, and disparate locations vis a vis power are readily acknowledged as problems in the contexts of nurse/patient encounters by these and other researchers, the same problems are rarely examined or acknowledged by researchers in the contexts of nurse/nurse encounters. In this section, I draw upon the very illuminating discussion by the above researchers (Kirkham et al., 2002) and apply it to interactions among nurses, beginning with the issue of "language".

In Chapter 5, Elena said that one of the factors keeping Filipino nurses in extended care is language: "Language is an issue, even though the language of instruction in the Philippines is English starting from the first grade. They are not sure how to express their thoughts sometimes", she said.

I mentioned in Chapter 5 that I observed some interactions between nurses of Philippines and Anglo European origins, and noticed that quite often the latter required the former to repeat what she had to say several times before understanding it. Moreover, the nurse of Philippines origin also often appeared at the beginning of such an interaction not to understand or "take in" what the other nurse was saying. On listening and comparing the speech of each person in the encounter, I noticed that the vocabulary and sentence structure of each were the same, with minor variations. Only the cadences of the speech (that is, the "accents") were different.

Citing Homi Bhabba, the team of researchers referred to above (Kirkham et al.,

2002; p.225) note that interpretation in communication is not simply an act of communication in a neutral space between the "I" and the "You", but takes place in a "third space" that is a site of negotiated identities. Moreover, in present day Canada, communications in hospitals and healthcare, as elsewhere, take place in a postcolonial context. Each participant in an interaction, therefore, brings to the encounter an identity that has been to some extent shaped by how they are situated in this post-colonial context.

In the interaction I was describing above, one nurse brought to the encounter a history of having origins in a colonizing, dominating nation (Britain or Europe); while the other nurse, a history of origins in a colonized and exploited nation. Borrowing further from the framework of the above authors (Kirkham et al., 2002; p. 228), one could hypothesize that the initial difficulty in communication between the two interacting nurses was related to the fact that people "are continually appraising exchanges as culturally safe or unsafe, depending on their individual interpretations of these encounters". This is likely to be particularly true if one or both actors in the encounter perceive themselves to be of unequal status or power. The Filipino nurse, for example, may have initially focused on evaluating the potential "safety" (Kirkham et al., 2002) or lack of safety in the ensuing encounter, to the exclusion of being able to "hear" what the other nurse had to say.

Each person in the interaction as it began was perhaps cued by the appearance of the other (the visual appearance of each bearing markers of their origins in the colonial past) to expect difficulties or even a lack of safety during communication. The possibility that a nurse from a racialized and marginalized ethnic group may expect

communication with a nurse from "a dominant group" to be "unsafe" is supported by my observations in Chapter 5 that two Filipino nurses appeared apprehensive, and that one stated she felt "like a lamb being thrown to the wolves" when she started to work in a Vancouver hospital. She attributed the "wolf"-like behaviour of some of her Canadian co-workers to the nature of people as "naturally territorial". A union officer quoted in Chapter 8 also used the wolf simile when describing the behaviour of a targeted nurse's co-workers, saying, "They are gathering like a pack of wolves". (Rather than arising from the attributes of people, however, one might alternatively interpret the "wolf"-like behaviour of the co-workers as an outcome of tensions arising from the upheavals and uncertainties of restructuring).

In Chapter 5, another Filipino nurse implicated "cultural differences" in job segregation, when she said, "There are cultural differences - a Filipino nurse would say 'maybe you might consider doing it this way', more subtle, softer, instead of ordering someone to do something. They would consider that bossy".

I noted in Chapter 5, that while nurses of Anglo and European origins may consider their own interactions towards others to be assertive and direct (a desired North American cultural trait), nurses from other origins receiving the interactions might consider them rude and belligerent. Styles of communication, then, are one aspect of how nurses act as "bearers of culture".

One Filipino nurse in Chapter 5 cited "subtle discrimination" as a factor keeping Filipino nurses concentrated in extended and sub acute areas. She said, "I know they said there are no discrimination, but there is discrimination subtly. ..people are not saying it, but you feel it... you said you are Canadian, but you still feel that you are not

Canadian”.

This nurse perceives that despite her official Canadian citizenship, prevailing attitudes make her feel that that she is not accepted as being “really” Canadian. Her perception illustrates “the taken-for-granted construction of Canadian-ness as more or less synonymous with being White, middle- and upper class, English-speaking, and of European heritage (Lee and Cardinal, cited in Kirkham et al., 2002, p.226). This construction of “Canadian-ness” aids in the construction of nurses as either “we” or “the other”.

The Filipino nurse who cited subtle discrimination as a reason for the concentration of Filipino nurses in extended care areas said that as a result of discrimination, said, “They [that is, “real” Canadians] don’t tend to recognize our potential; they don’t give us that opportunity, which I think we have all this potential to advance. But you have to really prove yourself”. This theme - “having to really prove yourself” was also expressed by another nurse in Chapter 8, who said about her manager: “She’s Oriental, too, so she has to prove herself”.

There is a mystique about the difficulty of critical care work, which contributes to keeping it relatively unattainable for many nurses. Hettie (a Filipino nurse) said that her sister, who is a critical care nurse in the U.S. “is really smart”. By implication, then, it takes more brains to work in critical care than it does in other areas. Critical care nurses themselves, however, do not claim to have more brains than nurses working in other levels of care. Rarely, a critical care nurse will dispel the mystique about critical care, and acknowledge to nurses in other levels, as one nurse did, “It’s just like anything, once you get to learn the ropes, it’s the cat’s ass”. More usually, though, she will say

little to nurses on other levels, and allow the mystique to remain.

The mystique of critical care work is linked to the rapid development of sophisticated technologies in biomedicine. As Harding (1991; p.2) observed: "Modern Western sciences and their technologies have always been regarded with both enthusiasm and dread". Note, here, that the advanced development of sciences and technologies is identified as "Western", even though it is disseminated throughout the world, its component electronic and other parts are assembled in various parts of the globe, and continuing research takes place to develop it further, conducted by researchers from around the globe. The identification of sophisticated scientific and technological developments as "Western" ignores preceding developments in mathematics and science, in "non-Western" areas of the world, which made such developments possible. The identification of advanced biomedical developments as "Western" contributes to the construction of what Lock (cited in Kirkham et al., 2002; p. 224) calls the "Western self and the 'non-Western 'other'". Lock (cited in Kirkham et al., 2002; p. 224) notes in relation to this, "a tendency to assume that 'ethnic minorities', 'immigrants' and 'patients' for example, are on the whole irrational, unscientific, and hence childlike or 'primitive'". The belief of the critical care nurse that Filipino nurses are "just more gentle souls" who do not want to work in ICU because "it's just not in their makeup" may reflect this assumption.

Hettie (a Filipino nurse) said that her sister works in a critical care unit in the U.S., which further calls into question the assumption that the nature of Filipino nurses makes them unsuitable to work in critical care. It calls into question any notion that Filipino nurses are less adaptable or suited to working in areas with sophisticated

"Western" biomedical technologies, while nurses of Anglo European origins are more suited to such work having been trained in the context of a supposed culture of "Western" biomedical technologies.

Some members of the Filipino Nurses Support Group whom I interviewed said that nurses trained in the Philippines were actively recruited to Canadian hospitals prior to the present period when the Immigration Department made it difficult for those nurses to gain enough "points" to gain acceptance as independent immigrants. When they were recruited for the profession of nursing, previously, they were recruited to work in all hospital areas. It is relevant to note here that the demarcation of critical care as a level separate from acute care took place during the time that Filipino nurses were still being recruited through the Immigration Department to work in Canadian hospitals. Imelda, a retired nurse of Philippines origin who worked in the critical care unit of a hospital that was closed in 1993, said that a cardiologist "set up" the unit and taught nurses from an acute care ward to read telemetries and closely monitor the conditions of very sick patients. The establishment of official "critical care courses" in colleges and hospitals, and the required certification, is a relatively recent phenomenon.

Social institutions outside the hospital, such as the Immigration Department, and its Live-in Caregiver Program (LCP), also reinforce job segregation. This finding is congruent with the finding of Ng (2001) that immigrant women of colour are allocated into lower echelon jobs through the articulation of the Immigration Department, employers, and a community job finding organization. In the present study, the LCP Program is an entry route for many nurses from the Philippines, which requires them to work as domestic workers for two years. At the end of the two years, these nurses must



take an examination to gain their credentials from the RNABC, and by the time they gain them, they usually feel that they have lost any acute care skills that they had to begin with, and therefore they tend to apply to extended care floors or facilities. This may be why Filipino nurses are more likely to be found in extended care floors and facilities than in other levels.

According to my interviewees, Filipino nurses working in extended care levels often perceive that they have no choice, or that if they attempted to transfer to another level of care it would not be worth it. Those who had to go through the lengthy process of getting registered with RNABC may not be keen to take on more challenges. Many are sending money home to relatives in the Philippines. They are compelled by their life circumstances to pay more attention to job security than to the more nebulous goal of self-fulfilment. A change to another floor or level of care could conceivably threaten job security if the nurses on the new floor were unfriendly. Once on extended care floors or facilities, then, Filipino nurses find safety in numbers in the face of a sometimes-hostile environment. Strength is needed to survive the sometimes-overbearing attitudes of some of the other nurses, and to keep from making any kind of mistake, no matter how minor that would incur censure.

Targeting and the fear of being targeted contributes to job segregation. We cannot draw conclusions based on this study on whether or not nurses from different ethnic origins, and from different locations in a post-colonial context, have equal chances of being targeted, given similar circumstances. Nevertheless, according to my interviewees, many nurses working in extended care and sub acute areas who are members of racialized ethnic minorities believe themselves to be more likely targets

than members of other ethnic groups. Differing communication styles between nurses of varied origins, along with their respective anticipation of difficulties in communication, may contribute to fears of being targeted. In addition, seemingly benign stereotypes about people and their countries of origin or ancestry may suggest that some people are more "naturally" suited than others to working in certain areas of the hospital.

Job segregation has been shown to be complex, multi-factorial, and related to forces outside the hospital, as well as to those within the hospital. A multitude of factors appear to be involved, that include: difficulties of foreign-trained nurses to have their credentials accepted; beliefs by Canadian-born nurses and other people about the quality of nursing education in formerly colonised countries; the "culture" of Western biomedical high technology versus that of medical systems in formerly colonised countries; lack of English language proficiency; life circumstances; personal preferences of nurses to work in one level of care over another; and perhaps, racism.

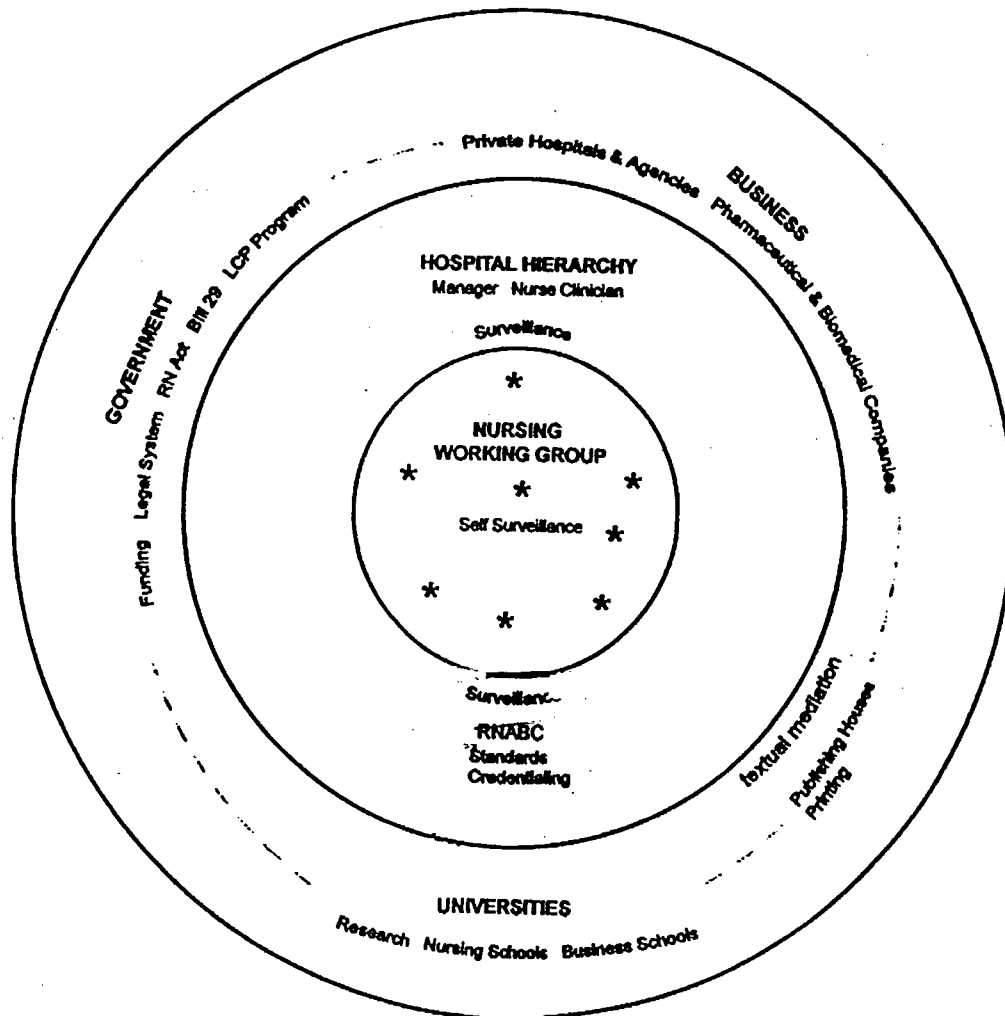
### **Restructuring and the "Relations of Ruling"**

As with other institutional ethnographies, the "relations of ruling" identified by Dorothy Smith have been ever-present during this study of hospital nursing work during restructuring. Due to decisions emanating from recesses of power hidden from front-line nurses and even from managers, hospital floors have been amalgamated or closed, as have whole hospitals. The process of restructuring of health care has been initiated at the highest levels of government, civil service, and business. Carrying out the policies of restructuring is the domain of hospital CEO's and executives, some of whom may be seen fleetingly as they travel to meetings at different hospital sites by the shuttle buses and taxis that connect them.

Head nurses who have become front-line managers notice that there are many more meetings to attend, presided over by administrators from higher levels, in which they must learn and transmit to front-line nurses the ideology, language and vocabulary of the new order, such as "patient focussed care". Due to a decision from some unidentified level of power, managers are also now responsible for administering budgets for their floor. From the point of view of the front-line nurses, the manager is frequently gone from the floor as she attends endless meetings. They sometimes witness groups of VIP visitors touring their wards. They notice hospital bulletins pinned or taped to walls with phrases like "protecting services through capturing savings", at the same time as nursing work has intensified due to increased numbers of patients to care for, and the increased acuity of those patients. Paid educational leaves for RN's appear to be no longer available. They notice that LPN's are starting to replace RN's, under the rubric of "skill mix".

Smith's conception of the hidden "relations or ruling", however, encompasses more than the official decision-makers and formal power. It refers to the tangled interconnection of institutions, largely unofficial and unrecognised, that exerts control and influence at the local sites of work - "the locus of the experience of the subject" (Smith, 1987; p.166) without people being aware of it. The "distinctive function" of health care (Smith, 1987; p.160) is surrounded by a complex of social relations that is best described, "not as a determinate form of social organization, but rather the intersection and coordination of more than one relational mode of the ruling apparatus". Through analysing this set of social relations (1987; p.166), she says, local work practices can be seen as articulated to and determined by the generalized and

Figure 1. The "Relations of Ruling" in Hospital Nursing



generalizing relations of economy and ruling apparatus.

One can see many strands of the interconnectedness in hospitals between government, business, academia, book publishing companies, and other aspects that together make up the "ruling apparatus". As illustrated in the diagram "'The Relations of Ruling' in Hospital Nursing" one level or component of this is linked to another component through "textual mediation".

"Accountancy practices" form part of the "relations of ruling". The "incident report" is an example: The nurse is responsible for monitoring the patients for any potential or actual side effects of drugs that she administers. If she fails to administer a drug that has been ordered, or if she dispenses a wrong drug, or a drug at the wrong time or by the wrong route, or if she witnesses another nurse doing any of those things, she must fill out an "incident report" that alerts her manager and the hospital administration. The incident report is a "constituent of the accounting practices" of the hospital, and as such, aids in the management of the nursing labour force, according to Smith's (1987) framework.

Just as the methodology of institutional ethnography would predict, one sees that nurses in their day to day working lives adhere to and even refine routines that are standardized and textually mediated in "procedural manuals" so that one work site is coordinated with numerous other worksites of which nurses in the work group may not even be aware.

The relations of ruling are not static, however. While taking on some tasks from

the domain of physicians, nurses are also in the process of relinquishing some tasks to lesser-qualified nurses, due to the demands of restructuring and cost containment. Hospital administrators who are replacing RN's with LPN's have invented new buzz words like "full scope LPN's" and "skill mix" to facilitate the change. The cost containment policy is made actionable for the organization through the new terms "full scope" and "skill mix". To become "full scope", LPN's are given hospital in-services in previously RN-only domains such as dispensing medications to patients. This policy would not be actionable or palatable if it were described as "replacing RN's by having lesser qualified employees learn the same skills". Procedure and policy manuals are being revised or rewritten to standardize and formalize the changes.

Anxieties have increased among hospital nurses about their ability to maintain competence when nursing work has intensified, routinized, and the nursing workforce has become partly casualised. The gaze of front-line nurses in hospitals, however, has been directed inward rather than outward, as they have tried to adjust to the extreme demands of nursing during restructuring. The potential challenge by nurses against what may turn out to be deleterious policies for health care and nursing has been deflected instead into a mass surveillance of themselves for inadequacies and "incompetence". Government legislation – Bill 29 – has complemented this effect by greatly weakening the fighting potential of unions who have agitated for decreased workloads, and have opposed casualisation of the nursing workforce, and privatisation of healthcare.

Thus, various constituent parts of the ruling apparatus are intertwined into the local sites of hospital wards – the nursing working groups - where people work and

interact, without it being apparent to nurses there. As a first step to reclaim agency, it is necessary for nurses to gain insight into how they are being affected by this confluence. An institutional ethnography can facilitate such insight, Smith (1987) says, through disclosing to women "how matters come about as they do in their experience, and by provid[ing] methods of making their working experience accountable to themselves and other women rather than to the ruling apparatus of which institutions are part" (p.178).

### **Significance of the Study**

In the present era of restructuring, the "crisis" of the health care system is uppermost in the minds of most British Columbians and in the rest of the country. The future of healthcare, and what it will eventually look like, is debated in the media, among members of the legislature, among policy makers, and among many organizations concerned about health care. For these "stakeholders", the present study can provide insight into the ramifications of restructuring policies. The study also provides insight into some previously unknown or unacknowledged aspects of workforce organization, such as the unofficial allocation of hospital work according to ethnicity and the ramifications of this on nursing work.

Funding for hospitals is a substantial portion of what our society spends on health care. The members of the nursing workforce are the hospitals' most numerous employees, and their role is crucial for the continuing efficacious functioning of hospitals and health care. The study makes an important contribution to the knowledge about how restructuring policies are affecting the work of hospital nurses, and how they are perceiving and experiencing the effects of those policies. It has implications for recruiting and retaining nurses. It also has implications for how policies affecting the

experiences of nurses ultimately translate into the relative efficacy of hospitals in terms of patient outcomes, which is measurable. The study has implications for present and future policies in health care and in hospitals, including policies about "skill mix", "public/private partnerships", and the replacement of head nurses by managers.

Suggestions for policy changes flowing from the results of this study, which follow, have relevance for the Ministry of Health and other policy makers at the governmental level; for hospital administrators and nursing management; for basic and post graduate nursing curricula; and for the nursing union and regulatory body. These suggested policy changes have implications for the quality of nursing practice, for the health and well being of nurses, and ultimately, for patient well being. High nursing turnover, burnout among nurses, and a shortage of nurses have been salient issues for over two decades (Price & Mueller, 1981). The data of the present study dramatize these problems, and the findings underscore the need to address the underlying causes. Policy measures based on these findings can be taken up by governments, hospital administration, unions, and nursing regulatory bodies, and could help to decrease tension on hospital wards, and increase the well-being of the care-givers on those wards which can only have positive effects on the quality of care delivered to patients in hospitals.

The study is also significant in terms of its contribution to the field of knowledge in the areas of social constructionism, labour process theory, and feminist writings in critical social theory. In addition, it brings these branches of thought closer together.

#### Implications for Policy Changes

The optimistic predictions that the new management styles accompanying



restructuring would result in the "empowerment" of nurses (for example, Gardner & Cummings, 1994; Perley & Raab, 1994; Sabiston & Laschinger, 1995; Tebbitt, 1993; Wilson & Laschinger, 1994) are not supported by the results of the present study. As one of the early steps in instituting business models into hospitals, senior administrators replaced head nurses with managers, assigning the latter the task of budget management for the floors, and requiring frequent meetings with them. In addition to being away from the floors more often, and preoccupied by non-clinical matters, the managers have acquired what is in effect an esoteric language and vocabulary that does not resonate with the front-line nurses whom they are presumably managing. The new vocabulary reflects and rationalizes the increasing distance between front-line nurses and managers: "head nurse" became "nursing unit manager" and then "patient services manager". Nurses have disappeared from the lexicon. Yet it is front-line nurses, largely unrecognized by management and administration, who are "the force, the persons behind the caring" (Shauna). It is they who carry out the day-to-day care for patients, without which hospitals could not function.

Front-line nurses, especially on acute care floors, do not have leadership from head nurses nor from their peers to the extent that they used to have before restructuring. Confidence among front-line nurses about their nursing practice comes from good leadership on the floor which was previously provided by head nurses and peers who modeled excellent nursing practice and provided informational support. Even managers do not feel supported in the environment of restructuring – "you are supported neither by upper management nor by front-line nurses" as one manager said.

Nurse clinicians, who were supposed to fulfill an educational and supportive role,

are also now referred to by depersonalized terms like "patient services coordinators", again reflecting and reinforcing a distance between themselves and front-line nurses. As a step towards addressing the deficit in floor leadership, and bringing about a more supportive leadership role for managers and nurse clinicians, both should don nursing uniforms and work side by side with front-line nurses at least part of the time. Managers should be relieved of non-clinical duties like budgets, which should be transferred back to the financial departments. This would facilitate closer, more mutually supportive relations between managers, nurse clinicians, and front-line nurses. Managers (or "head nurses" as they may once again be called) should become members of BCNU once again.

Hospital administrators and nursing managers should provide and encourage paid educational leaves for front-line nurses, as well as frequent in-services and workshops given on the floor, so that nurses can become experts on clinical care in their own right. This would facilitate their remaining or becoming informal leaders on the floors, and their being able to "mentor" and give more support to new nurses. It would also provide a means by which management could "give back to nurses" (Shauna) and show that they recognize and respect them.

In tandem with giving paid educational opportunities and workshops, the administrators need to hire more full-time nurses so that the nurse to patient ratio is higher, the pace of work is less intensified, and nurses have more time to give more thoughtful care and mentor other nurses, especially new ones. Paid educational opportunities, along with the expectation and encouragement for front-line nurses to do conceptual work, and the support and encouragement for more autonomy in clinical

decision-making, would decrease the divide between physical and conceptual work, and would result in more satisfaction among nurses with their work. Such policies would also show dividends in terms of hospital reputations: hospitals in the U.S. with such policies are known as good employers and care providers and are characterized as "magnet hospitals" (Laschinger, Almost, Tuer-Hodes, 2003; Upenieks, 2002, 2003).

The government needs to fund more seats in nursing schools to address the shortage of RN's. The policy of replacing RN's with LPN's should be suspended until there is a thoroughgoing understanding of the implications of this policy in terms of patient outcomes. Already, some researchers have shown a correlation between lower mortality and morbidity of patients, with higher numbers of RN's (in proportion to lesser qualified caregivers) in Canadian hospitals (Estabrooks, Tourangeau, Humphrey, Hesketh, Giovannetti, Clarke, Acorn, Wong, Thomson, & Shamian, 2002; Tourangeau, Giovanetti, Tu, & Wood, 2002). Saving money ("capturing savings") in the short run cannot be an adequate rationale for policies that jeopardize health (and cost more money) in the long run.

The BCNU and other unions in health care should be supported rather than undermined, and legislation like Bill 29 by which the government and health employers can renege on collective agreements, should be repealed. Collective action and the collective strength of nurses needs to be encouraged, not only for the physical and mental health of nurses, and the resulting benefit of the patients, but also for the benefit of health employers in the long run, who would otherwise be met with other informal kinds of action such as calling in sick. "Contracting out" clinical health services to non-unionized employees, which is happening at present with "support services", would

result in an amorphous group of individuals competing with each other for work. Such a situation would exacerbate tendencies towards dysfunctional interactions already present and noted in this study. "Team work" among nurses – nurses functioning well as a working group with members mutually supporting each other - is very important to nurses and it is crucial for good nursing practice.

It is very important to support the vital role that unions, stewards and union labour relations officers play in averting or attenuating the effects of targeting episodes and other dysfunctional interactions. The present provincial government and health authorities have been taking measures to weaken or disperse unions. This is a serious mistake and should be opposed. Weakening the strength of unions would likely have the effect of weakening the feelings of collective strength and solidarity that members of unions feel, which they need for their own health and well-being and which they need to counteract the destructive effects of negative workplace environments. They need the collective means of changing their situation when it is unbearable. As mentioned previously, workplace environments could be decidedly worse, and nurses could resort to other unofficial means of resistance, such as increased days off sick, or quitting.

It would be naïve to suggest that the results of this or other studies should convince governments and policy-makers at higher levels to adopt the above suggestions for policy changes. At the top levels of power, there is a fierce ideological divide between advocates for the primacy of the "market" and advocates for "the welfare state", and it is the former that is prevailing at the present time. We must remember, too, that restructuring and the introduction of the business model into health care began to happen in British Columbia under a political party that identified itself with

the ideology of the welfare state. There are contradictions in the "relations of ruling" that are not readily apparent to most people, nor amenable to any control by ordinary people. In the long run, the problem of people being completely marginalized from political power, and the problem of how to work out the means to solve that problem, is the compelling task of the present era. Without solving that main problem as it presents itself, all talk of major policy changes with regard to restructuring can only be empty talk.

In the meantime, however, front-line nurses, managers, and others can agitate for smaller policy changes like some of those discussed above. They can also organize informal study sessions on topics like the implications of restructuring policies. Study sessions could also include topics like targeting, and how competence and incompetence is socially constructed, so that nurses may gain insight into how larger forces outside the hospital are affecting their interactions and experiences on the floors. "Culture", as a negotiated and shifting entity, is another possible study topic. These study sessions could be combined with or modeled on present informal organizations by front-line nurses, like the wine clubs and book clubs. Similar study sessions or workshops should take place in nursing schools, as well, in order to forewarn and prepare nursing students about how to negotiate entry into nursing working groups when they start their first jobs. Workshops could feature typical scenarios that might arise, and how the new nurse might act in them.

In the realm of organizational "culture", measures to increase the respect for front-line nurses need to be taken. This would include encouraging other professionals to dialogue more with front-line nurses directly about the patients they are caring for,

rather than discussing them only with “experts” like nurse clinicians.

Targeting and other dysfunctional interactions on the nursing floors need to be seriously acknowledged and confronted at all levels of the hospitals through concerted efforts of managers, administrators, unions, nurse clinicians and educators, and front-line nurses themselves. One step towards this is to make targeting a legitimate field of study, taught in nursing schools and post graduate nursing courses, in management schools, and in on-site seminars accessible to front-line nurses. Courses would include practical tips for managers and nurses on, for example, how to read and respond to cues from members of a working group that they are feeling anxiety and tension.

The interactive environment of nurses would improve greatly if the above mentioned suggested policy changes were carried out. Concomitantly, targeting would undoubtedly decrease or disappear if the conditions for it were not present.

#### Implications for Theory

This study contributes to the fields of social constructionism, labour process theory, and to standpoint research. Social constructionism in this study cannot be confused with relativism – a recent criticism of it of late. In the present study, social constructionism is “situated” in a sociopolitical context, thus contributing to a bridging between social constructionism and critical social theory. This bridging overcomes the problem, not previously addressed in social constructionism, that individuals do not have equal power in an interaction to decide its interpretation and outcome. The interactions are often not innocuous.

This is illustrated in the interviews between Susan and the manager in Chapter 8, where Susan was fighting a losing battle to have her interpretation of events prevail,

which would protect her identity as a competent nurse. Although Susan was able to use tactics to attenuate and delay the severity of the manager's intended outcome to the interview, the manager had the final say over which interpretation would prevail, as shown when she said "Patsy said that is what happened, so that is what happened". Social constructionism, however, reveals in minute detail how the power is exerted, which is not apparent on merely looking at a map of hospital hierarchy. It offers the hope that by understanding *how*, nurses can gain insight into and some control over the effects of structural determinants on their working lives and interactions.

The study mitigates against simplistic and essentialist assumptions about gender oppression, since it illustrates how class and ethnicity are also involved in the oppression of nurses. It also illustrates that the triad of "race, class and gender" cannot be used as a simplistic explanatory tool to analyze the oppression of nurses or any other group of people.

The large amount of empirical data in the study contributes to a better understanding of how restructuring has affected the work and experiences of hospital nurses. The large amount of empirical data also contributes to labour process theory. The findings support Braverman's (1974) thesis about the degradation of work, insofar as nursing work has intensified and routinized during restructuring, with an increasing divide between conceptual and physical work. Unlike in the Braverman discussion, however, technology in the present study has symbolic meanings rather than being tied to developments in the nursing labour process. Buroway's (1979) finding about "game-playing" had its corollary on some acute care nursing floors, where nurses found satisfaction in working very hard and quickly. On most acute care floors, however, they

did not have much choice about how fast they had to work, and did not enjoy working too fast, as it meant there was less time to think about what they were doing, which contributed to anxieties about competence.

The findings of this study are germane to the sociological and epidemiological study of inequalities in health and health care. There is ample epidemiological and sociological literature showing a strong correlation between health outcomes, and the factors of self-esteem, identity, occupation, ethnicity, class, and gender (for example, Aitken, 1995; Anderson, Blue, Holbrook & Ng, 1993; Anderson & Lynam, 1987; Arnold, 1996; Aston & Lavery, 1993; Bolaria, 1988; Bryan, Dadzie, & Scafe, 1985; Doyal, 1995; Fernando, 1992; Franks & Faux, 1990; Hare & Pratt, 1988; Haynes & Feinbeib, 1980; Hemmons, 1996; Henry, Tator, Mattis & Rees, 1995; Johnson, 1989; Lewy, 1991; Mason, 1995; Messias, Im, Page, Regev, Spiers, Yoder, & Meleis, 1997; Province of British Columbia, 1995; Tomaskovic-Devey, 1993; Torkington, 1995; Weitzman & Berry, 1992), but there has previously been little research investigating how these factors manifest themselves at the workplace site, nor the pathways through which they ultimately result in differential health outcomes. The findings of this study help to illuminate some of those pathways.

### **Limitations of the Study**

The study was carried out over a brief period of time, so that it is like a window that offers a still frame of nursing under restructuring, which is a continuous ongoing process.

Data in this study was collected mainly from two hospitals in Greater Vancouver. Thus, important differences that may exist between hospitals within the city, and



differences between hospitals in larger and smaller urban centres, may be missed. One reason why this could be important is related to the different demographic compositions of large urban centres compared to smaller towns. This is due to increased migration to Canada from "non-traditional source countries" (Beaujot, 1991; Depass, 1992) – that is, from "third world" countries - starting in the 1960's and 70's. Most immigrants settled in the large urban centres of Canada, rather than in small towns. Therefore, one may wonder, does job segregation within the nursing workforce exist in hospitals in small towns? If it does, then is it on the basis of ethnicity or some other factor? Other questions remain unanswered also, such as how restructuring has affected nursing work in smaller towns, compared to large urban centres.

The planned cross sectional survey for this study did not materialize, as discussed in Chapter 3. Given the time frame of the present study, it would have been too time-consuming to obtain representative numbers of respondents to the questionnaire from each level of care. A quantitative survey, as a triangulated source of data, would have strengthened the study in terms of generalizability.

A cross sectional survey could also have helped to clarify the phenomenon of job segregation on the basis of ethnicity: for example, questions could have been included concerning where the nurses received their training, whether or not they were first or second (or more) generation immigrants, and what beliefs they held about the quality of credentials obtained elsewhere than in Canada. This is a possible area for future research, which could be addressed by both qualitative and quantitative methods.

For the qualitative part of the study, on the other hand, the small number of hospitals was desirable, as the criteria on which this research is evaluated differs from

that of quantitative research (for example, credibility and confirmability versus validity and generalizability). Drawing on extensive data from a small number of subjects or cases, the findings of this study provide in-depth understanding of particular phenomena and issues, which can go beyond the particular setting to inform research in other settings.

### **Areas for Future Research**

More research is needed on the problematic aspects of hospital nursing work that have been revealed in this study. These include the effects of the routinization of work, and the division between the physical and conceptual aspects of nursing work. What are the long-range effects of routinization of nursing work, and routinization of thought, on patient care and patient outcomes? Relatedly, what is the long-term effect of replacing RN's by lesser-qualified personnel, who have much shorter training and educational periods? More research studies into the effects of restructuring on nursing work and nurses' well being should be conducted, and correlated with patient outcomes.

There are numerous studies on the effects of "privatization" and "public/private partnerships" (PPP's) on health care in the U.K. These need to be reviewed, meta-studies need to be compiled, and more studies initiated in Canada on the effect of PPP's on the health care system here, and on patient outcomes.

Practical measures on how to prevent or circumvent dysfunctional patterns of interaction on hospital floors are an urgent area of investigation. This also has implications for policy changes in hospital and health care administration. It would be fruitful to provide funds for participatory action research in this area.

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## Appendix A

### Questionnaire

What kind of floor/unit do you work on?

2. How long you have worked on this floor/unit?

☐ < 1 yr    ☐ 1-2 yrs    ☐ 3-5 yrs    ☐ 6-10 yrs    ☐ > 10 yrs

3. Do you work ☐ full-time    ☐ part-time    ☐ casual

Your age: ☐ 20-29 yrs    ☐ 30-39 yrs    ☐ 40-49    ☐ 50-59    ☐ 60 -65

What is your ethnic background?

What kind of work do your parents/father/mother do? (or if retired, what kind of work did they do?)

Are you

☐ married    ☐ single    ☐ living with a partner    ☐ sep/divorced, widowed

8. Do you have children living with you? ☐ Yes    ☐ No

9. What kind of nursing work do you do on this floor/unit? (Examples)

-  
-  
-

10. How does it differ from work on other floors? (Examples)

-  
-  
-

11. How is that you chose to work on this particular floor/unit?

12. If you had your choice, would you: ☐ stay here, or ☐ work in another type of floor/unit?

Do you have much of a choice about where you could work? ☐ Yes    ☐ No

☐ I'd have no problem changing to another floor

☐ I would probably experience some problems if I changed to another floor  
(Specify)

Can you list things that would make a "good day" on your floor?

-  
-  
-

Can you list things that would make a "bad day" on your floor?

-  
-  
-

What is a "good nurse"?

If you could pick the ideal nurse to work with, what would she/he be like?

If you constructed a scale for the floor/unit: (a) how would you rate yourself on it?

☐ Ideal Nurse   ☐ Good Nurse   ☐ Average Nurse   ☐ Below Average

(b) How would you rate others on the floor/unit? (approximately how many individuals would you put into each category?)

What do you enjoy most about working with other nurses?

Would you say that nurses are mutually supportive?

☐ Always   ☐ Most of the time   ☐ Some of the time   ☐ Rarely

How do nurses show support to one another?

What do you enjoy least about working with other nurses?

Would you say that some nurses on the floor/unit are targeted or given a hard time?

(a) ☐ This happens a lot    ☐ This happens occasionally    ☐ Seldom  
Examples?:

(b) Can you think of ways that this could be prevented or stopped when it does happen?

How would you describe your health?

☐ Excellent    ☐ Good    ☐ Fair    ☐ Poor

Do you feel anxiety and tension at work?

☐ Always    ☐ Most of the time    ☐ Some of the time    ☐ Never

How would you rate your overall level of happiness and well-being?

☐ Very high    ☐ High    ☐ Average    ☐ Low    ☐ Very low

Please add any comments that you feel would be useful to know, but were not covered completely by the questionnaire (you may use the other side of the page):

## APPENDIX B

### **Letter of Information About the Proposed Study**

Title of the Study: Working in the Hospital Floor in the Era of "Restructuring"

To Registered Nurses: I am asking for volunteers to participate in a study about the working environment of registered nurses in hospitals, which I am conducting as part of my requirements for the PhD program in Sociology at U.B.C. The purpose of the study is to gain more understanding about aspects of the working environment of nurses through studying their perceptions and experiences of that environment.

I will interview each participant one to three times (depending on your time available) over a period of several months. Each interview should last no longer than one hour, and would take place in a conference room on the ward, at your home, or at some other agreed upon location. During the interview, which I would like to tape, I will encourage you to share your observations about being a RN on the hospital floor. Full confidentiality will be maintained: your name will not be used in the study notes in the final report, nor will the name of the hospital where you are working be mentioned. No one at your work facility, or anyone else other than my dissertation committee will have access to the study notes. During the writing of the dissertation, I will be composing "composite stories": that is, bits and pieces from various interviews will be made into one story, thus no information would be identifiable as coming from any one person.

Although there is no monetary compensation offered, the dissertation and possible published papers resulting from this study may contribute to improved working environments for RN's such as yourself.

If you are interested in taking part in this study, or you would like to know more about it, please contact me at:

Thank you.

Sincerely,

Anne Jamieson, R.N., MSN.



## APPENDIX D: TWO EXAMPLES OF "FLOW SHEETS"

NURSING CARE FLOW SHEET											
<b>Legend:</b> I - Independent      T - Total Care S - Supervised      NN - Refer to Nurses' Notes A - Assisted											
Date											
Time Period											
Initials of nurse assigned to patient											
EXCRE- TORY	CT - Catheter	Urine									
	CM - Condom										
	I - Incontinent	Stool (#)									
INGESTIVE	N - Normal	Diet (T - Therapeutic)									
	B - Blenderized										
	MS - Mechanical Soft	Eating Poorly									
	FF - Fluid										
	CF - Clear Fluid	Eating Well									
	P - Pureed										
NPO	Weight (kg.)										
PROTECTIVE	HYGIENE	Sponge Bath									
		Tub Bath									
		Shower									
		Mouth Care									
	SKIN INTEGRITY	Intact									
		Turns									
	SAFETY	P - Posey	Restraint								
		W - Wrist									
		M - Mitts	Bed Rails Up (x1) (x2)								
		LT - Lap Tray									
LR - Lap Restraint											
REPARATIVE	MOBILITY AIDS	Bedrest (+D = Dangle)									
		C - Cane	B.R.P.								
		CR - Crutches									
		W - Walker	Chair								
	WC - Wheelchair	Walking									
	REST DURING NIGHT	Slept Poorly									
Slept Well											

<input type="checkbox"/> L <input type="checkbox"/> R Procedure: _____		<h1 style="margin: 0;">RESTORATIVE PHASE</h1> <h2 style="margin: 0;">HIP FRACTURE</h2>	
NURSING CARE FLOWSHEET NOT NECESSARY.			
Focus of Care	D	N	ALC when outcomes met & D/C path.
			DATE: _____ PO Day _____
1. Delirium	<input type="checkbox"/>	<input type="checkbox"/>	Assess and treat risk factors for delirium: PRISM- E (pain, retention, restraint, infection, impaction, sensory impairment, meds, alcohol, metabolic - hypoxia, malnutrition, fluid & electrolytes, environment). Review and provide brochure. Safe Medication Administration in the Elderly. Date: _____
Desired Outcomes	<input type="checkbox"/>	<input type="checkbox"/>	Free from delirium according to the CAM
2. Pain	<input type="checkbox"/>	<input type="checkbox"/>	Assess pain q4h & administer Tylenol regularly and prescribed analgesics as ordered, assess effectiveness. Provide analgesic prior to potentially painful activity
Desired Outcomes	<input type="checkbox"/>	<input type="checkbox"/>	Level of pain to operative hip is within acceptable pain level/ participates in ADL's / Mobility ♦
3. Impaired Resp	<input type="checkbox"/>	<input type="checkbox"/>	OB until mobile
Desired Outcomes	<input type="checkbox"/>	<input type="checkbox"/>	O2 SAT ≥ 91% ♦ Respiratory status WNL for patient ♦
4. Impaired C.V.	<input type="checkbox"/>	<input type="checkbox"/>	Sequential compression device while in bed or chair. Remove q shift for 20 minutes. D/C SCD when mobilizing TID. Date D/C _____
Desired Outcomes	<input type="checkbox"/>	<input type="checkbox"/>	VS within normal range. ♦
5. Impaired Fluid & Electrolyte, lab values	<input type="checkbox"/>	<input type="checkbox"/>	Monitor lab values. Report abnormal readings to physician
Desired Outcomes	<input type="checkbox"/>	<input type="checkbox"/>	Blood values are within normal limits
6. Skin breakdown	<input type="checkbox"/>	<input type="checkbox"/>	Reposition q4h when in bed or sitting until patient moving independently
Desired Outcomes	<input type="checkbox"/>	<input type="checkbox"/>	Free of skin breakdown
7. Impaired Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	Assess dietary intake, supplement as required Consult dietitian if intake consistently < 75% of meal. Date _____ Encourage fluid intake 1500 cc per day unless contraindicated
Desired Outcomes	<input type="checkbox"/>	<input type="checkbox"/>	Tolerating diet / eats 75% of meals provided.
8. Impaired Elimination	<input type="checkbox"/>	<input type="checkbox"/>	Toilet q4h during the day. Assess need to void with turns. Up to commode at least twice daily. Bladder scan I/O catheter prn x 2 if > 200 cc. Bowel protocol. Last BM date: _____
Desired Outcomes	<input type="checkbox"/>	<input type="checkbox"/>	Voiding well without difficulty Normal bowel pattern for patient
9. Infection	<input type="checkbox"/>	<input type="checkbox"/>	Assess incision. Remove dressing and expose to air if no drainage. Remove staples PO Day 12 if wound healed Date D/C _____
Desired Outcomes	<input type="checkbox"/>	<input type="checkbox"/>	Incision to hip is free from redness, swelling and drainage
10. Anxiety & Fear	<input type="checkbox"/>	<input type="checkbox"/>	Assess patient/family concerns re: discharge destination and date, loss of independent function, pain, recovery plan. Counsel, teach and support. Refer to SOCW as indicated. Date if Consult _____
Desired Outcomes	<input type="checkbox"/>	<input type="checkbox"/>	PT/family state that concerns are being addressed
11. Discharge Planning	<input type="checkbox"/>	<input type="checkbox"/>	Tentative Discharge Date: _____ Assess suitability of discharge destination. OT <input type="checkbox"/> SW <input type="checkbox"/> Update discharge plan on Kardex Home OT Arranged <input type="checkbox"/> Assess need to consult HC liaison. Date if consult: _____ Home PT Arranged <input type="checkbox"/>
12. Impaired mobility/function, falls risk	<input type="checkbox"/>	<input type="checkbox"/>	OT / PT teaching as per hip fracture protocol OT <input type="checkbox"/> PT <input type="checkbox"/> OT/PT recommend assistive devices / mobility aids. Assess need for hip protectors. OT <input type="checkbox"/> PT <input type="checkbox"/> OT to ask family to bring in clothing / supportive footwear. <input type="checkbox"/> Falls Prevention Teaching - reinforce and review First Step Booklet. <input type="checkbox"/> Functional assessment: (eg: functional mobility, personal care) as per care plan OT <input type="checkbox"/> PT <input type="checkbox"/> OT to complete personal care on bedside careplan / PT to complete mobility on bedside care plan. OT <input type="checkbox"/> PT <input type="checkbox"/> Encourage family to observe/assist with ADL, transfer & ambulation PT hip exercise protocol <input type="checkbox"/> OT dressing assessment <input type="checkbox"/> assisted <input type="checkbox"/> independent OT Bathing / shower transfer practice. <input type="checkbox"/> PL /family state that they are able to continue exercise program independently ♦ PT <input type="checkbox"/> PL /care givers able to master: dressing, toilet transfers, tub/shower transfers. ♦ OT <input type="checkbox"/> PT <input type="checkbox"/> Assistive devices and home equipment arranged. ♦ OT <input type="checkbox"/> Sit in chair X _____ hours per day ♦ OT <input type="checkbox"/> PT <input type="checkbox"/> Achieves activity goals: Transfer: _____ Ambulation: _____ Stairs: _____ ♦ PT <input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	If concerns re mood/motivation consult family, GDS screen & refer to geriatric/GP if indicated. Date of GDS _____
Desired Outcomes	<input type="checkbox"/>	<input type="checkbox"/>	Depression detected and referral sent where warranted. Date of Consult _____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Refer to attending/GP if osteoporosis is untreated
Desired Outcomes	<input type="checkbox"/>	<input type="checkbox"/>	Detection and treatment of osteoporosis where warranted
Social Support	<input type="checkbox"/>	<input type="checkbox"/>	Team refers to community linkages as warranted eg. OT <input type="checkbox"/> PT <input type="checkbox"/> SW <input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	MMSE if delirium or cognitive impairment. If score is less than < 25 / 30, follow up with GP <input type="checkbox"/>
Desired Outcomes	<input type="checkbox"/>	<input type="checkbox"/>	Arrange for GPOT, STAT Centre etc SW <input type="checkbox"/> Referred for dementia / delirium cognitive assessment and support where indicated. Staff must initial on reverse side →

## APPENDIX E: EXAMPLE OF A KARDEX

Date	SATIATIVE	Date	PROTECTIVE - REPARATIVE	Date Ord.	LABORATORY TESTS	Date Done
	<input type="checkbox"/> Glasses <input type="checkbox"/> Hearing Aid		ALLERGIES (red)			<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>
			Transport for tests: <input type="checkbox"/> Walking <input type="checkbox"/> W/C <input type="checkbox"/> Stretcher			<input type="checkbox"/>
			<input type="checkbox"/> Bed <input type="checkbox"/> Mobilizer			<input type="checkbox"/>
	<b>RESPIRATORY</b>		Activity			<input type="checkbox"/>
	VITAL SIGNS <input type="checkbox"/> D.O. <input type="checkbox"/> N.O.		Safety			<input type="checkbox"/>
	<input type="checkbox"/> O <sub>2</sub>					<input type="checkbox"/>
			Hygiene		Specimens for Collection	<input type="checkbox"/>
						<input type="checkbox"/>
			Treatments			<input type="checkbox"/>
						<input type="checkbox"/>
	<b>INGESTIVE</b>					<input type="checkbox"/>
	<input type="checkbox"/> Feeds Self <input type="checkbox"/> Set Up Tray <input type="checkbox"/> Assist <input type="checkbox"/> Total Feed				<b>DIAGNOSTIC PROCEDURES</b>	<input type="checkbox"/>
	<input type="checkbox"/> Intake <input type="checkbox"/> Dentures					<input type="checkbox"/>
	Diet		<input type="checkbox"/> Teaching			<input type="checkbox"/>
						<input type="checkbox"/>
			<input type="checkbox"/> Isolation			<input type="checkbox"/>
	<input type="checkbox"/> IV		<b>AFFECTIVE-EGOVALUATIVE-ACHIEVING</b>			<input type="checkbox"/>
			D/C Plan			<input type="checkbox"/>
						<input type="checkbox"/>
					<b>MEDICAL - SURGICAL PROCEDURES</b>	
	<input type="checkbox"/> Saline Lock					
	<input type="checkbox"/> Weights Scale		<input type="checkbox"/> Planned Ther. Comm. N.C.P.#			
	<b>EXCRETORY</b>		NEXT OF KIN:			
	<input type="checkbox"/> Output		Phone:			
	<input type="checkbox"/> Catheter		<b>CONSULTATIONS &amp; REFERRALS</b>			PO ____
	Last BM ____		<input type="checkbox"/>		Diagnosis:	
			<input type="checkbox"/>			
			<input type="checkbox"/>		History:	
			<input type="checkbox"/>			
			<input type="checkbox"/>		<input type="checkbox"/> LTC q ____ <input type="checkbox"/> Demo VC PCH ____	
Bed No.:	Name:	Age:	Admitting Doctor:	Adm. Date:		