Charting a Course:

An Exploration of the Construction of Nursing Practice

by

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ABSTRACT

This thesis examines the ways in which nurses' work is embedded in the institutional hierarchy of the Canadian health care system. The study uses data from a project sponsored by the Registered Nurses' Association of British Columbia. The project, as conceived by the Association, established a stand-alone nursing centre in a small community on Vancouver Island. The RNABC described the project as one which would encourage nurses to experiment with new and innovative forms of nursing practice. The project was intended to provide a setting in which nurses could demonstrate their practice outside of the usual constraints of traditional health care settings. The study asked "how will nurses structure their relationships and networks and what nursing practice will emerge?" The experiences of local nurses working in the project are analyzed using the methodology known as institutional ethnography. In this method the stories of individual nurses are taken as entry points through which the wider network of social relations may be explored. Links not visible to those engaged in the work are explicated leading to an enhanced understanding of how local events are shaped by extra local control. The study argues that nurses' actions and choices are embedded in the social relations of Canadian health care, and that the regulatory function of the professional association itself

nurses within health care. It draws critical attention to how nurses participate in their own subordination in taken for granted ways.

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Introduction

Nurses in Canada are charting a course, seeking a new direction for nurses in the world of health care delivery. This is not a movement which has just begun. Nurses have been thinking and working toward this goal for years. Some stops along the way include the Nurse Practitioner movement and the idea of the advanced practice nurse (Henning and Cox, 1994). My story is set in a Nursing Centre, set up to explore some alternate roles for nurses in a community setting.

In 1994 the Registered Nurses' Association of British Columbia (RNABC) opened a Nursing Centre in the Comox Valley, on Vancouver Island. This thesis examines some aspects of this high profile project. My purpose in this thesis is to draw analytic attention to how nurses and nursing are embedded in the social relations of Canadian institutions and society. This embeddedness of nurses' action and choice is something that, I argue, is overlooked in the RNABC's Nursing Centre proposal, or, at least, the significance of the social organization of nurses' work is underestimated. I will argue that nurses' relation to the health care system is not simply a matter of their historical subordination to the medical profession although that is important. Rather I hope to demonstrate how the RNABC's regulatory function played out in an implementation

strategy that coordinated and controlled the work of the Comox valley nurses. My contention is that this regulation or ruling function continues to perpetuate a view of nursing which reinforces within nursing the ruling relations of the health care hierarchy and hinders change.

My interest in this project stems largely from my own nursing past. My nursing career covers the period of evolution of the nurse administrator as a distinct entity. Within the organization in which I work this move has resulted in some increased power for the nursing department. Nurses are more in charge of their own work and its administration. At the same time the trend has been to reward nurses by moving them from the bedside to administration and to encourage the acquisition of administrative credentials.

An introduction to the work of Canadian sociologist Dorothy Smith at this point in my career provided new ways of understanding how my small cog fits into the larger wheel. It also provided me with an interest in looking at nursing as a whole; how practice comes into being, and how my practice as a manager may affect, and be affected by, a more general process of administration. Smith's contribution includes, amongst others, showing how everyday life in this

kind of society is administered through textually-mediated processes, and how disjunctures are created between people's experiences and how they are worked up to be administered. Smith (1987) uses the term "problematic" to describe her particular attention to the "everyday world". She explains:

> The concept of problematic is used here to direct attention to a possible set of questions that may not have been posed or a set of puzzles that do not yet exist in the form of puzzles but are "latent" in the actualities of the experienced world (p.91).

Using this notion of a set of latent puzzles, the specific focus of my research is a puzzle at the heart of a project which aims to expand the boundaries of nursing practice - the Comox Valley Nursing Centre. The evaluation proposal for the Centre states that the project:

> is intended to explore and demonstrate a nursing facility and program which both fits the strategic directions for health care of the Ministry of Health and exemplifies the roles that nurses can play in this new and developing health care environment, outside the constraints of the more traditional settings where nursing is presently located (RNABC, 1993, p.3).

Nursing as a discipline has a history of practice which is defined by others, and the opportunity for some nurses to define nursing practice for themselves appears to be supported in their proposal. This is an exciting concept, including as it does the "notion of nurses working closely as partners with others" and the proposal that nurses will "through their consultations with others and through their

nursing practice, both define and address the unmet health need within the community that fall in nursing's domain". (RNABC, 1993 p.4)

The language of the proposal speaks of the project as outside the usual constraints which operate on nursing practice and this is where I see the puzzle beginning; this project implies that the RNABC recognizes that barriers constraining nursing exist within the current practice settings. The Association does not claim that there will be no constraints in the new setting. However no mention is made of how freedom to develop might be achieved.

My own experience with the development of a new (in 1983) paediatric outpatient program in an acute care hospital led me to identify two important constraining operating factors there: the limited allocation of financial resources; and the limited time frame for the project. I struggled for several years to implement a program originally designed for a larger staff. At each budget justification period I was expected to produce statistical evidence that the program was successful. The program had a high component of counselling and telephone coordination, neither of which fit well into the standard outpatient workload measure of visits. Although there was some limited understanding that

the practice did not fit the standard outpatient model this understanding did not extend to the accountability structure. At each budget discussion the program was viewed as a 'cadillac' service, with an unusually high ratio of staff to patient visits. This was in spite of the fact that the change of practice supported a number of families to care, at home, for children who had previously been admitted to hospital.

I see similarities between my previous experience with this program and the situation for the nurses in the Comox Valley. The evaluation team for the Comox Valley project have recognised the difficulties inherent in evaluating this project and are using a variety of research strategies to capture both the process and the practice which emerges. Nevertheless I see that the failure to clearly explicate the range of potential barriers sets up some "latent puzzles" to be explained. My experience in a similar situation suggests that in implementing a new program, nurses face the prospect of being held to account by standards which may not apply to the new situation.

Through the members of the evaluation team at the University of Victoria I was offered the opportunity to participate as a research assistant in the documentation of this project.

My own research data were collected during the final planning phase and first months of actual operation of the Centre, and my research question focused on the organizing work of the nurses living and working in the Comox Valley, and those who were employed in the new Nursing Centre. I asked, how will nurses structure their relationships and networks and what nursing practice will emerge? My inquiry was designed to explore how this project's organization was going to facilitate new practice. The standpoint of the nurses of the Comox Valley was my entry point for this exploration.

I approached my exploration with a number of underlying ideas and pre-conceptions which needed clarification. Through the process of a literature review (chapter One), I looked for ways in which the work of the nurses could be understood and placed into its organizational and historical context. Nursing in the 1990's is the product of the previous century of practice. I also explored the background of current nursing thought. The language of the RNABC's discussion paper is an implicit acknowledgement that a power imbalance exists. Although not stated specifically the RNABC's desire to expand the role of nursing must be understood at some level in terms of power, and this has been related in nursing literature to the espousing of

feminist principles. As a feminist I also wanted to explore nursing's connection, or lack of connection, with feminism to the profession's current standing in the hierarchy of health care. I was led to look at nursing's place in the health care hierarchy and the role played by the gendering of knowledge. What is clearly stated in the RNABC's discussion paper is the association's intent to promote a partnership with the community. I looked at some examples of community development models in an attempt to understand the social structure in which the nurses' work evolved.

In Chapter Two I outline the underlying principles of the method of enquiry developed by Dorothy Smith, known as Institutional Ethnography. The method leads the researcher to identify links and connections between the research problematic and social relations which are not easily visible to those engaged in the work, but which shape what actually happens. The value of this method lies in the enhanced understanding of how local events, in this case nurses' work in the Centre, are structured when these links are brought into the light, explored and understood. In Chapter Three I provide an outline of the project as the context for my study.

Chapter Four begins the data analysis and I explore the

planning phase of the project. The RNABC established a structured approach to planning and organizing the project. I argue that the Association's control over the project created tensions, and had a negative impact on the local nurses' ability to work with community members in defining a new understanding of nurses' work. What this means in terms of the goal of developing a new way of working is that from the beginning nurses were constrained to an expert model that matches the traditional hierarchial approach of the health care system.

In Chapter Five I examine the early stages of the nurses' work within the Centre. I use the text based documentary system, initially implemented in the Centre, as a beginning point to explore ways in which the accounting of work exercises control. Specifically I look at the acceptance within nursing of the notions of objectivity and the ways in which this can impact the relationship between nurse and client. What I saw happening was the documents and computer-based recording driving the nurses' ideas and actions.

Chapter six closes my analysis, and in it I look, briefly, at the relationship between physicians and nurses in Comox as it began to be played out in the Nursing Centre. I argue

that nurses continue to recreate the historical subordinate relationship between the two professions, and I contend that the RNABC models a continuation of this approach.

Chapter One - Conceptual Framework

To consider the ideas of the Comox Valley project I needed to begin with an exploration of the literature on nursing practice. The RNABC speaks of an expanded role and of demonstrating the full scope of nurses' practice. First I wanted to discover how these notions are presented in nursing literature. The language of the RNABC's Nursing Centre proposal implies an openness to innovation and an opportunity for creativity. Nevertheless it would be naive to assume that the endeavour begins with a blank slate, that the nurses involved in the project would be free of any history, or socialization that would affect their creativity. The practice of the nurses begins in the context of what is currently understood. Hiraki (1992), in a study of introductory nursing texts, described tradition as "a Heideggerian concept of an individual's pre-understanding of reality" (p.4). In the context of nursing she means that practice builds on a perceived reality which is generalized extensively and is accepted un-reflexively as truth. In what follows, I explore this tradition as it appears in the literature.

Nursing in theory

In this section I provide a critical overview of the role of nursing theory in the development of nursing as a profession, and in the achievement of autonomy of practice.

First I look at the history of modern nursing. Florence Nightingale is largely regarded as the woman responsible for modern nursing as she produced the first formal description of a nursing activity and organised ways to replicate it in a consistent manner. Nightingale described nursing as an activity in which observation of the patient and the environment would lead to an understanding of health. She established a practice based on nursing observation. According to Fitzpatrick and Whall (1983) Nightingale was "explicit in defining nursing knowledge as distinct from medical knowledge and nurses as independent from physicians" (p22). Nightingale's vision of nursing was not sustained in the face of opposing social forces in the decades following her work.

Chinn and Jacobs (1983), described the gap which they see in nursing's formal development. They identify the development of the health care system and rapidly evolving medical technology as factors which relegated nursing to a subservient position during the first half of the twentieth

century. Although their practice is based in the United States, Chinn and Jacobs relate this evolution to nursing in general. Their view is supported by Torrance (1988) in his examination of the evolution of health care delivery in capitalist countries. Torrance described several key factors which resulting systems have in common and which have served to institutionalize medical hierarchy. Chief amongst these factors was the appropriation of the ownership of knowledge by physicians who were thus very well placed when discoveries of the nineteenth century brought about the beginning of curative medicine. Perceived improvements in medical knowledge led to an increased demand for this service. The existing dominant profession of medicine consolidated ownership over what Torrance calls the "healing enterprise", and its organizational structure. Coburn (1988) noted that this control over the institutionalization of health care had "serious implications for women's role in medicine. Once independent practitioners, they were denied training and were thus relegated to a subservient position within the medical profession." (p.446). According to Chinn and Jacobs (1983), in the first half of the twentieth century nurses were viewed as "submissive, obedient, and humble women who would be used to further the economic and technologic goals of medicine" (p.24). From this history, in the second half of the twentieth century, nurse scholars

began to develop the work, and the writing, which would attempt to form a new tradition for nursing.

Although nursing and feminism have been uneasy with each other (Chinn and Wheeler, 1985, Vance, Talbot, McBride and Mason, 1985), the women's movement of the last three decades provided an environment which was supportive of a changing view of nursing. Nursing leaders have responded by writing enormous amounts of literature (Ingram 1991) which seek to recapture Nightingale's confident assertion that nursing owns a unique place in the delivery of health care. Production of this literature is closely linked to changes in the style of nursing education which moved from an apprenticeship style of training to an academic pursuit based in community colleges and universities. Increasingly, nursing leaders accepted the idea that in order to gain greater credibility nursing needed to develop a theoretical base of practice (Chinn and Wheeler, 1983, Fitzpatrick and Whall, 1983, Fawcett, 1984). Authors of nursing literature argued that theory based practice would allow nurses to both identify and communicate nursing practice. It would also assist nurses to establish their field of practice and prevent other professions from taking on aspects of care which nurses wanted to own (Chinn and Jacob 1983).

As I explored the literature I began to feel I had taken on a daunting task. I discovered as many as twenty-four theories in a single text (Marriner, 1986) representing a number of different meta-theory alignments. There were also varying opinions on the level of sophistication, and on the potential or actual contribution of the theories to improvements in nursing practice. Fawcett (1984) addressed the multiplicity of nursing theory by outlining a structural hierarchy of knowledge and placing a metaparadigm consisting of four concepts at the apex. The four concepts identified by Fawcett as central to nursing are: person; environment; health; and nursing. Few would argue with Fawcett's distillation, and her concepts link nursing with the vision of Nightingale. The more difficult task is to link these concepts with activities which can be labelled as "nursing". There appears to be a disjuncture between the abstract articulation of nursing and the actual practice.

> There is agreement within nursing that nurses and their clients are in relationships concerned with health or health problems. While many nurses agree on highly abstract and complex concepts, they have many disagreements, much fuzziness, and multiple conceptual problems when they try to use the concepts for the transmission of knowledge as a rational base for practice. (Ellis, 1982, p.410)

As I studied I continually asked myself what theoretical knowledge would help me to understand the experience of the nurses in Comox.

Theory and practice

The RNABC was clear that their goal was to demonstrate an expanded scope of practice and so I began with a simple question. Given the amount of theoretical literature why is this project necessary? I then explored questions arising in the literature regarding the usefulness and validity of available theories. The very multiplicity of nursing theory has opened the door to criticism of nursing's claim to professional status. It is argued that nursing does not own a well defined body of knowledge. This argument has been refuted by the counter claim that nursing's pluralistic approach is, in itself, a strength. Hayne (1992), discussing the evolution of nursing as a discipline is amongst those who take this latter view "because it [plurality] provides several departure points for nursing practice, research and education" (p.105). Hayne however overlooks another important point, that the theories and knowledge which purport to guide a body of women's work were developed without any attention to the women's perspective. The profession became "bogged down ... with nursing theories which evolved from the social sciences" (Keddy, 1992, p.8), theories which were predominately based in the male view. Ehrenreich and Ehrenriech, cited by Coburn, talk about the seduction of professionalism which allows nurses to "participate - however vicariously - in the very real status

of the doctors" (1988, p.459). In a similar argument, Ellis and Hartley (1992) contend that nursing has been hampered by a "lack of separation or obvious distinction from medicine" (p.5). However their own vision of advances in nursing practice is strongly linked to nursing's ability to work with sophisticated medical technology, a vision which is also tied to the medical model. Keddy (1992) agrees "we have modelled ourselves after the male "scientists" whose respect we fought for in order to achieve status, distinction and some degree of recognition" (p.8).

The preoccupation with professional recognition through adoption of the scientific paradigm may have eclipsed early attempts focusing on caring as a legitimate theoretical base. Keddy argues that the history of nursing as a history of caring work may have been eclipsed in nursing's efforts to achieve professional status. MacKay (1993) agrees, "the rejection of the caring and nurturing aspects of nursing in favour of technology and psychomotor skills has hampered the development of nursing's knowledge base" (p.36). Hiraki's (1992) detailed analysis of introductory nursing texts concludes that analytic science was the dominant paradigm represented. She argues that nurses then value this approach to the detriment of caring, intuitive knowledge.

Keddy believes that the feminist movement in nursing is bringing the relevance of existing nursing theory into question. While not as explicitly critical as Keddy, there is some support in the nursing establishment for the idea that nursing as a profession is best understood in the social context of the women's movement. For example, "nursing as a largely female occupation must be seen within the context of [the] broad social changes in gender roles and in women's conceptions of themselves" (Baumgart and Larsen 1988, p.9).

Yet the disjuncture between a predominately female profession and the male oriented scientific paradigm does not entirely explain why nursing continues to struggle to define itself. The dilemma touched on by Chinn and Jacob (1983) - the seeming discrepancy between theory and practice - is examined more rigorously by Purkis (1992). Purkis argues that nursing literature treats theory as if it is detached from practice. "In conceptualizing theory as something which comes after practice, there is a danger of ignoring the theory which in fact drives practice" (p.10).

Purkis, like Keddy, is implying that much current thought about nursing rests on insecure or irrelevant foundations. Keddy decries an absence of feminist theory and Purkis

advocates for an understanding of both the context of nursing practice and its implications. Both Purkis and Keddy are calling for a better match between nursing as a set of activities and the ideas and concepts which purport to describe and explain them. My concern about nursing theory is that in defining nursing in prescriptive terms we ignore, or make invisible, the real people involved in real actions in the real world.

> Clearly practice does not happen haphazardly; much preparation goes into making it happen and making it happen in particular ways. These ways are accomplished by actors emphasizing certain actions and excluding others. (Purkis, 1992, p.21).

In Purkis' study the choice of particular actions is influenced by the work which the nurses must accomplish and for which they are accountable. This directs attention to the topic I want to explore. I am interested in the ways in which nurses come to understand exactly what work will be emphasized.

The ideas represented in the work of Purkis, Keddy, and others attempt to address an important concern for nursing: the general failure of theoretically based practice to deliver on the promise that autonomy over how nursing work is conceptualized and done will bring real power to the profession. In 1983 Chinn and Jacob argued that: "professional autonomy and power will come from the

development of theoretical knowledge in nursing" (p.6). In the next section I look at some nursing literature which addresses the profession's continued concern with a lack of autonomy of practice.

Feminism, power and nursing

Concern over nursing's perceived lack of autonomy is reflected in nursing literature of the 1990s. The profession is increasingly aware of its inability to practice independently; for instance : "within health care settings nurses as a group practise with relatively little power ... they have too little authority to implement programs against the wishes of other vested interests within their occupational environment" (Chavasse, 1992, p.2). The concept of feminism is linked to the concept of power equalization, but I argue that feminist ideas, as represented in nursing literature, do little to add to a useful understanding of how power is experienced. In this section I look at the understanding, or rather the lack of general understanding, of power and how it is experienced in the everyday world. The work of Dorothy Smith is introduced to explore ways in which power can be understood to be gendered, and how it is routinized in the relations of Canadian society.

The profession's lack of autonomy is not always described in terms of power. Some see nurse's problems as their inability to identify and work with other stakeholder groups (Baumgart and Larsen, 1988). In the Comox Valley project the RNABC clearly had a similar philosophy; on the other hand, attempts to utilize nursing expertise in community settings, where other stakeholders would have less apparent control over nursing practice are not necessarily successful. One familiar example is the original attempt to introduce Nurse Practitioners into health care in Ontario. In the face of an opportunity to deliver a new style of primary health care the Nurse Practitioners Movement in Ontario was smothered. "Policy decisions about Nurse Practitioners were in complete contradiction to the research findings" (Manga, 1992, p.19). In the same article Manga notes that this did not occur in a vacuum. "The demise of the Nurse Practitioner movement served the interests of the doctors wonderfully" (p.19). In this instance the other stakeholders apparently had sufficient influence to block nursing's attempt to promote a change of health care delivery.

Instances such as the experience of the Nurse Practitioner movement underline for nurses their inability to effect change against "vested interests". Chavasse's (1992)

discussion of power speaks of it as an amorphous non-contextualized concept. Other stakeholders have "it" and nursing wants more of it. A cursory review of nursing literature suggests that there is much more involved in an adequate analysis of power and nursing. While much of the discussion of nursing's problems avoids the topic of power altogether, a typical example is the advice given by Maglacas (1988)

> To be successful, nurses need to understand better the agendas and priorities of key decision makers and others who influence public policy ... Nurses must become much more effective communicators with such groups. In addition if they are to extend their power base to influence policy formulation they must overcome their distaste for politics and also learn to use information and marketing techniques (p.69).

Missing from this discussion is an understanding that power, in health care as in society, is socially constructed in the relations of society and that "power" to be analyzed helpfully must be discovered as it appears in the practice of health care workers. It is not simply 'out there'.

The present analysis attempts to open up this discussion of power in relation to nurses and the Comox Valley Project. Nurses' place in health care might be better understood if we see how power is part of everyday life, including social relations within nursing. Campbell (1994) has argued that the "knowledge work that nurses do, both in their present work and in work associated with population based health

care involves them continuously and interactively in maintaining the very relations they are trying to overcome" (p.3).

Campbell's understanding of power is not well represented in nursing literature. Lacking any such analysis of social relations the advice given in nursing literature, such as that given by Maglacas (1988) and cited above, remains abstract. How and where to utilize political skills is unstated and unexplained. Articles of this type can also have the unintended effect of disempowerment, failure to achieve results is interpreted as a failure to act correctly. Nurses are seen as the problem.

Earlier I suggested that feminist ideas had been absent from nursing's theory development; twenty years ago there was almost no mention of feminism in mainstream nursing journals (Amos, 1994). This situation is changing and an increasing number of nurses are recognizing the effects of sexism (Chinn and Wheeler, 1985). Although there are articles addressing feminism the focus is primarily on selling ideas inherent in the women's movement and continuing to add converts to the cause (Keddy, 1992, MacKay 1993). The assumption presented is that the adoption of feminist principles by a majority of nurses would unproblematically

lead to an increase in power. Vance, Talbot, McBride and Mason (1985) cite Florence Howe:

> Rather than bemoaning the fact that women numerically dominate teaching, nursing and social work professions, why not consider the fact important strategically? ... Women should focus on building their potential for strong and effective leadership in those areas where they are currently numerically dominant ... To focus feminist energies on those fields would be to develop "women-power" and to change three of the most important service institutions in society. (p.282)

Implicit in these exhortions to take control, take power, is the assumption that nursing only needs to get it together in order to effect change. Adamson, Brisken and McPhail (1986) point out that the idea that women could solve their problem if they just tried harder is related to the dominant ideology of change. They argue that this kind of thinking is based in the philosophy of individualism. The authors reject the usefulness of "individual" solutions to women's problems saying:

> in fact we would argue that individuals' ability to change themselves or, indeed, to exercise control over their lives, is limited by the structures and relations of power. Society is not made up of atomized individuals but of classes, races, and genders who share unequally in the power and privilege and who often face irreconcilable conflicts (p.141).

The authors further argue that the relations of power "are embedded in all Canadian institutions, such as schools, the work place, and the state" (p.137). In my study I want to move beyond explanations that are framed in relation to

individuals and explore institutional arrangements. Seeing power as institutionalized is an important step towards understanding the invisible net which constrains nurses' ability to define and shape their own practice. It is a step towards understanding why the extensive collection of theoretical descriptions of nursing have not translated into autonomy of practice.

Dorothy Smith's work provides an explication of the institutionalization of power. In her work on the gendering of knowledge Smith (1984a) traces the historical separation of the male and female domains of knowledge and the link between gender separation and the acquisition of power in industrialized societies. In an article that develops an account of how this happened Smith begins with the European Renaissance of the fifteenth and sixteenth centuries and sees the growth of capitalism as the starting point for this division. The Renaissance, in Smith's view, was "an expansion of male activity and power arising in the radically new modes of social relations which capitalism brought into being" (p.71). Smith's work provides the historical roots of the gender sub-text in which we live and links it explicitly to ownership of knowledge and skill. She argues that capitalism moved production outside of the home, one result of this being the "progressive

appropriation of the skills and knowledge of women" with a corresponding transfer of power away from women and the work done in the home. Control of production brought power to the men who owned the resources and organized the productive work. This included power over the knowledge of production. The appropriation of knowledge and skills was not limited to the production of material commodities. Smith describes that in health care "women were progressively excluded as men established a monopoly, or at least final control, over the practice of medicine" (p.73). Implicit in Smith's discussion of gendering of labour and knowledge is the understanding that the ruling relations which flow from this organization of society are so routinized that they have become invisible.

The routinization of which Smith speaks can be seen in the textual organization of society:

> our knowledge of contemporary society is to a large extent mediated to us by texts of various kinds. The result, an objectified world-in-common vested in texts, coordinates the acts, decisions, policies and plans of actual subjects as the acts, decisions, policies and plans of large scale organizations ... The knower's relation to the object known is structured by the social organization accomplishing it as knowledge (1990, p.61,63).

We can see this happening in the following description by Purkis of a health promotion nursing interaction. Purkis (1992) describes a "health promotion" interaction between

parents and nurse in which we can see "ruling" as a set of interactions between nurse and clients organized by a text. At the beginning of the interaction the nurse completes a standardized assessment form including some physical measurements of the child. Purkis points out that only those aspects of the child which are relevant to the form are sought by the nurse. Unique and idiosyncratic aspects of the child, possibly known only to the parents are "stripped away". In this way the nurse constructs knowledge of the child which fits with the parameters of her own knowledge thus constructing herself as an expert knower. In so doing she is able to require the parents to attend to her "instructions" relating to parenting, nutrition, and so on. This is an example in which Purkis captures a view of power, with which Smith would agree, as institutional, relational and socially constructed in a text-based interaction. What we do not see in this story is how the profession and its mandated practices are also features of larger social relations of health care in which professionals participate as privileged stakeholders. Smith's method of analysis helps make these connections.

In an earlier work Smith (1975) argued that the construction of textual knowledge does not occur by chance. Smith explores a field she defines as "the social organization of

knowledge", and, within it, the part that social organization plays in the relation between the knower and the known. As described in the example above the structure of a document plays a significant part in the construction of a "fact". Smith picks apart the construction to reveal the largely invisible process which occurs. She argues that the structuring of the documentation is not accidental, rather it deliberately constructs and serves the ruling process. Ruling depends upon a knowledge process in which information about what is to be managed (ruled) is categorized. As we saw in Purkis' health promotion example, the observational and documentary work of categorization "selects" from any experienced event those aspects which fit the category. For nurses and others involved in such processes there is a particular effect. It produces a tendency to "reproduce the world as those at the top said it had to be" (Smith, 1975, p.266).

Nurses in the health care system

Nurses work within the social relations of Canadian health care and society. Their place within the system has not occurred by chance. In this section I outline the history of the current health care hierarchy. I also discuss the notions behind self-regulatory legislation as a professional marker, and relate this to the governance of nursing in

British Columbia. I look at the historical context and at the current Nurses (Registered) Act. My examination of the social organization of ruling in health care suggests that even when nurses are removed from traditional agencies and the ruling practices in them, they are not operating outside the professional realm nor outside the social relations of health care. They operate within, and as my interpretation of Purkis' work shows, they maintain the ruling relations of the health care system. What then are the ruling relations of the Comox valley project?

The current emphasis on cutting health care costs and the prevalence of corporate style management systems is reducing the power of the physician within the hospital (Wahn, 1988). However the continued prevalence of the curative model of care promotes the primacy of medicine under current health care legislation (Rachlis and Kushner, 1994). The historical context establishes two issues of interest. First the embededness of the relative positions of nursing and medicine within the hierarchy of the health care system. Secondly, although they have had differing success, both professions have sought to use the state to further their members' interests. An understanding of nurses' work and their place in the health care system begins with an understanding of the professional organization of nursing in

British Columbia as it currently stands. The relationship of nursing to the medical profession is, of course, an important feature.

The regulation of the health care professions is tied to the evolution of health care services in Canada, and the success, or other wise, of the various health care provider groups in achieving control over their own practice. George Torrance (1988) provides an overview of the development of the health service industry in capitalist societies:

> At a high level of generalization, the health systems of capitalist nations at similar levels of economic development are much alike. In response to similar forces and by diffusion, such nations have adopted fundamentally similar institutions for providing health care: **a hierarchy of healing occupations and professions under a dominant medical profession** (emphasis added, p.7).

According to Torrance, physicians as a group were strategically placed to achieve ownership of the medical discoveries of the late nineteenth century and to gain dominance over the "healing enterprise":

> because of the social origins of physicians, their association with elite educational institutions and their favourable connections with socially and politically dominant groups, physicians with the aid of the state achieved dominance over the healing enterprise (p.7).

Torrance describes the beginning of modern health care organization, and he argues that being a dominant provider group, before public demand for the service grew, was a key

factor in the physicians' success. His historical account suggests that demand for health care service began with the emerging middle class, and spread to the working class and the poor. By the 1960's the middle class had generally embraced some form of financial insurance as an attractive method for ensuring service for themselves, and this method of financing services was adopted by the state as it moved to provide health services to all citizens. The intervention by the state into what was initially a private enterprise threatened the dominant group but physicians as an organized profession were successful in resisting changes which threatened their autonomy:

> In almost all cases the physicians were partly successful; they retained almost total control over the content of their work, and in many cases control as well over the way health care was organized ... Medical control over key institutions like hospitals and paramedical occupations went unchallenged (Torrance, 1988, p.9).

Physicians were able to retain control because they already had it. Control over the organization of health care was an important factor in the early institutionalization of a health care hierarchy in Canada and thus in the ultimate relative positions of the various players. According to Coburn's historical analysis (1988):

> Although the medical advances led to a decrease in mortality rates, the new institutions were hierarchic, undemocratic and removed from the community to such an extent that many extremely valuable aspects of the old community health-care system were lost. The institutionalization of health care had serious

> implications for women's role in medicine. Once independent practitioners they were denied training and were thus relegated to a subservient position within the medical profession (p.446).

Nurses were not unaware of their competitive disadvantage in the early days of the Canadian institutionalization of health care. They recognized the role the state had played in organizing and regulating health care delivery and nurses sought to establish their own professional boundaries through the use of legislation. The Canadian National Association of Trained Nurses was formed in 1912 and began to work towards establishing requisite registration and towards moving nursing education out of the hospitals and into educational institutions. By 1922 all of the provinces had some form of registration legislation but the acts varied widely and "were full of loopholes (Coburn 1988, p.455). The struggle to move nursing education away from a hospital based environment and into community colleges took many more years. Beyond that, the next goal the organized profession set itself, to make the nursing entry level credential a baccalaureate degree, has not yet been achieved.

The current Nurses (Registered) Act of British Columbia was passed in 1988, replacing the act of 1979, and bringing into law significant changes from the previous legislation. The act enforces mandatory registration for all nurses

practising in British Columbia and it delegates to the RNABC the authority to impose registration renewal requirements. Prior to the current act the legislation allowed the RNABC to establish requirements for initial registration but, failing disciplinary action, renewal was then automatic on payment of a membership fee. Additionally nurses who had not fulfilled registration requirements were legally entitled to work as "nurses" in the province provided they did not take the title of Registered Nurse. Typically these were nurses who had received their training outside of British Columbia and they were classified by employers as "graduate nurses". Under the 1988 legislation the RNABC made provision to grandmother in those nurses currently working as "graduates" and this effectively eliminated that work category. The net effect was to eliminate a group of working nurses who practised outside of the control of the professional body. The current act thus enhances the self regulatory control of the profession and the successful achievement of the legislative change was viewed by nursing as a victory - a signal that the profession was gaining in autonomy.

Self-regulation may be an important step towards autonomy but as evidenced by the following discussion, autonomy is, perhaps, still elusive for nurses. Self-regulation is a

term which implies a high level of autonomous practice, nevertheless as Pal (1992) points out it is still a form of governmental authority:

> ... self regulation as the term implies, is an instrument whereby the state delegates its regulatory authority to a particular group, which then fulfils the public interest by monitoring and controlling its own affairs. In practice this means that the group forms an organization or association to monitor member's behaviour and compliance with regulations. The organization also has disciplinary powers which it exercises on behalf of the government. Leading examples of self-regulation come from the professions ... The logic appears to be that as professions these occupations define their own special expertise, which is best monitored, certified, and disciplined by their own members (Pal, 1992, p.158).

This form of policy instrument has obvious attractions for governments, they are able to present a perception of arms-length control, but in practice may retain significant influence. For example the Nurses (Registered) Act delegates control over the education of nurses to the RNABC but this authority is diluted by the dependence on government funding for education programs. The association's inability to implement a policy of baccalaureate education as an entry level requirement demonstrates this quite clearly. Although I question the ability of the act to promote autonomous practice for nurses in general, it is clear that the act does provide the RNABC with significant control over the practice of individual nurses. Renewal of active registration requires nurses to demonstrate that they have engaged in some form of nursing

activity for a specified number of hours over the preceding year. The determination of "nursing practice" is set by the association and thus allows them to control the work which is to be known as "nursing".

Fundamental to self-regulatory acts is the delegated authority to control practice. This authority includes the right to discipline members and take away membership privileges and it is commonly accepted as a critical feature in determining the professional status of an occupation. The notion that specialized knowledge is needed to accomplish the regulatory function - and an occupation has that knowledge - helps to support the claim for recognition as a profession. The attraction of the idea was demonstrated by nursing's campaign to achieve the latest amendments to the current Act which was a rare example of successful coordinated lobbying by nurses throughout the province. Yet the Act does not achieve the kind of monopoly of practice which physicians have been able to accrue to themselves. The language of the Nurses Registered Act and the Medical Practitioners Act are superficially similar; both share legalistic terms which provide the necessary authority to delegate control. The power which the Medical Practitioners Act is able to exert is found in an important variation which captures an essential difference between the

two pieces of legislation. The Nurses (Registered) Act provides control over the use of the title "nurse" but the protection exists in control over credentialling requirements. The Act does not attempt to establish ownership in the legal sense over any set of practices. The Medical Practitioners Act on the other hand establishes both control over the title "doctor" and very specific ownership over areas of practice, indeed establishing hegemony over related professions. So far physicians in British Columbia have been very successful in defending their practice against challenge.

Lacking ownership of a specific set of practices, nursing legislation has had the unintended effect of turning nursing reflection inward. The RNABC has focused attention on the development of standards of practice and attempted to define and articulate the scope of nursing practice, attempting to build a professional domain of its own without challenging its legally defined subordinate relation to medicine. This focus plays a significant role in the way in which the association interacts with its members. The emphasis on standards and evaluation encourages entry into a textually mediated practice which in itself acts to limit the scope of practice. In the practice setting the use of standards and evaluation is translated into a series of predetermined

actions and outcomes. While this provides the professional organization with the tools to control the activity labelled as nursing, it also serves to limit the exploration of new ways of practice.

There is a contradiction built into the standard approach to professionalism that is mandated for the regulation of nurses by the Nurses (Registered) Act. Nurses working in British Columbia are required to enter into a relationship with a mandated association organized in a standard hierarchial format. There are many excellent reasons for the choices made by the association, not the least being the need for legitimacy and acceptance in dealings with other similar associations, and with the provincial government. Nevertheless there are consequences to the strategies chosen. In a paper on political empowerment, Mason, Backer and Georges (1991) see professionalization as at best a double edged sword:

> the issue is a complex one that is at the heart of nursing's dilemma of how to be empowered within the health care system and in society without perpetuating inequality. Should nursing adopt the practices of its oppressors or should it challenge the traditional notions of what defines a profession? (p.73).

Mason and her colleagues write of the tendency of professionalization to perpetuate inequity: their concern is with the disempowering effect of this division. The authors critique professionalization as the route to

empowerment. I am concerned with how professionalization is understood and plays out in the context of nurses' actual work. I see a potential disjuncture in the ideas of nurses as expert practitioners and the ideas of partnership, collaboration, and the client as expert. My concern is that this potential problem is apparently not identified by the RNABC. The concepts of community and partnership are unexplored in the association's position papers. Rather the concepts stand as unquestioned right. My research interest is in pursuing how the relations between the professional association and the nurses of the Comox Valley Nursing Centre are structured and how these sets of contradictions play out in nurses' practice in the new setting.

Nursing as community interest

'Primary health' is among the changes that the nursing profession is embracing in its goal of making nursing more relevant and more competitive in the heath care stakes. Moving to a community model has a variety of benefits as government policy witnesses. As health care is increasingly community based, nurses are working to demonstrate their community based skills. The Comox Nursing Centre Project is one such initiative. In a discussion paper on Primary Health Care (1990) the RNABC identified the importance of two concepts: "the community as client" and "from provider

to partner" (p.6). The association's hypothesis is that achievement of their goal of supporting the World Health Organization (WHO) concept of primary health care can be furthered by working in and with communities. The Comox Valley Nursing Centre is intended to demonstrate the effectiveness of a community or primary health model of health care provision.

There are many questions which might be addressed in an exploration of the community involvement in the Comox Valley project. As with the nursing literature I was in danger of becoming overwhelmed by the sheer volume of publications on community health initiatives. I looked primarily for writing which would assist me to understand the relationships which might emerge in Comox. What organizational structures shape the work? How do the relations between clients and agencies develop? How are the agencies accountable, and to whom?

The RNABC appears to link community participation to partnership. In a critical analysis of the history of community development Jane Dixon (1989) examines how relationships between agencies and clients evolved: "Even when adopted by non-government agencies community development has been generally an intervention imposed from

the outside for the good of those inside - it has been a paternalistic intervention" (p.88). According to Dixon the process often "accepts and does not challenge the existing local power relations" (p88). In addition she claims that "the beneficiaries are most likely to be middle class groups who can contest the power of bureaucrats, developers, and other identifiable groups with power" (p.88). Dixon's analysis challenges the idea of partnership as a natural outcome of community based initiatives.

One of the most extensive experiences with health related community development in Canada exists in the province of Quebec. As a comparison to the Comox Valley project, Quebec's experience with local community service centres is perhaps the most relevant. The Quebec program set up multidisciplinary centres to provide health and social services, with a stated commitment to administration by community run boards. A report by O'Neil (1992), twenty years after the centres' inception, addresses the question of community participation. O'Neil found that "the role of users and representatives of the socio-economic groups consists more in managing the agencies than in defending the community's interests" (p291). O'Neil's comments echo the experience of the volunteer board described by Roxana Ng (1988). The accountability required of the board is

expressed in the relationship to the funding agency rather than to the agency clients. This has the effect of directing attention to the management of the accountable activities in order to appear successful. Questions relating to the appropriateness of the activities are then overlooked. According to O'Neil "overall, participation in these agencies has been a failure, and the incredible growth of services outside the system (for instance in alternative medicine) is eloquent proof that citizens were not able to shape the system to meet their needs" (p.291).

O'Neil's discussion supports Dixon's contention that existing power relations in the community continue to play a dominant role. In addition however, O'Neil indicates that professionals running the centre were able to exert their own power: "the general director and the staff were in a position to build up, consciously or not, their own power base along technocratic and professional lines and to effectively take over the orientation of the organization" (p.294). Ng's work differs from that of Dixon and O'Neil in a way that is important to my inquiry. Dixon and O'Neil reported and described the power relations which they found in community health centres after a considerable period of operation. They found a discrepancy between the stated goal of partnership between community and provider, and the

actual practice of the centres.

Ng's analysis was of the agency as it developed and working relations crystallized. She showed ways in which practice and power relationships evolved out of organizational features in which the agency was situated. In my study and through the Comox project I am interested in gaining an understanding of how involvement of the community might affect the social relations of the Comox Valley project.

In a related discussion on communities and social change, Wharf (1992) examines the relationship of community organizations and policy change. Wharf's work deals with the profession of social work. He uses a series of case studies to examine the potential for influencing social policy reform at a local community level. Nursing and social work share many common concerns relating both to the kinds of clients they serve and membership in corresponding professional organizations. Wharf's work presents a guarded optimism for grass roots influence which is encouraging for the Comox Valley project. Nevertheless his work also points out that:"as noted earlier, the closer reforms approach the grand issues of redistributing power and income, the greater the resistance" (p.199). And, as I have shown is the case for nursing, Wharf notes that traditional social work models

pay insufficient attention to the ways in which power is operationalized in society.

The work which nurses do is shaped by the context in which they work. And, more importantly, this context is formed by a complex network of social and ruling relations which are institutionalized and largely invisible. Given this view of the institutional context, the research question which I want to answer is: are nurses' activities relating to the development and operation of the Comox Valley Nursing Centre constrained in ways that encourage them to fit into an existing ruling system?

Chapter Two - Methodology

> When stripped to their essentials, debates over methodology are debates over assumptions and purposes, over theory and perspective (Taylor and Bogdan 1984).

Throughout my conceptual framework I have presented some of the many arguments for choosing to take a feminist perspective in approaching this thesis. The explicit choice of a methodology, as noted by Taylor and Bogdan, implies a set of values and beliefs. It also implies the choice of certain approaches to the research project. I have chosen institutional ethnography and interpretive research. These terms are linked to the feminist perspective used in this research. I will therefore discuss these ideas before describing details of research methods.

According to Parker and McFarlane (1991) "the pathways of feminists and nurses are once again converging" (p.60). The authors argue that the characteristics of feminism, particularly the awareness of what they call "life as a whole", and the rejection of the idea of research providing objective truth, are of value in guiding nursing research. The term feminist research however covers a gamut of

approaches as Sandra Harding (1986) notes when she says "clearly, there are contradictory tendencies among the feminist epistemological discourses" (p.28). These contradictions are reflected in divergent opinions in nursing literature regarding the definition of feminist research. Parker and McFarlane, for example, list as the first of a number of criteria that the researcher must be a woman. This view is refuted by Campbell and Bunting (1991) "biologic female sex is neither necessary nor sufficient to be a feminist" (p. 5). Implied but not explicitly discussed by Campbell and Bunting is the descriptor "interpretive". Not all feminist work can be categorized as interpretive, but much of it falls within this paradigm. This form of work is discussed below.

Interpretive research

Interpretive research, as the term implies, situates the researcher as interpreter and explicator. Smith (1987) sees the feminist researcher as the person with the ability to straddle two worlds, the local and the extralocal. Smith's own experience, as a woman, mother, and single parent convinced her that the **"disclosure** [my emphasis] of the extralocal determinations of our experience does not lie within the scope of everyday practices. We can only see so

much without specialized investigation, and the latter should be the [researcher's] special business" (p.161). This is a distinctive feature of the approach I use in this study. In Smith's work, discussed in more detail later, the feminist stance is reflected in the interpretation of the everyday experiences of women.

The ideas, generally speaking, of interpretive research run directly counter to the concerns of a more conventional view of research. For example, notions of objectivity and bias in methodology are handled differently. Objectivity and bias are concepts linked to the positivist or non-interpretive paradigm and assume the possibility of an objective stance on the part of the researcher. Harding (1986) discusses the pervasiveness of objective methodology in research carried out in the social sciences saying that "the social sciences have tried to imitate the dispassionate, objective methods supposedly responsible for the growth of knowledge in the natural sciences" (p.20). The objective view includes the notion of distancing the researcher from the researched:

> science supposedly speaks in the voice of no particular social individuals; the inquirer is always to make himself as a distinctive social personage invisible to the audiences for the results of his inquiries" (Harding 1986 p.229).

In the scientific view, bias is a breakdown of the procedures which are intended to produce and preserve objectivity. That is, the findings or conclusions are affected by "an inclination or preference which makes it difficult or impossible to judge fairly in a particular situation" (Gage Canadian Dictionary, 1983). The view that I take is that the belief that a pure objective approach can be applied to human issues is in itself a bias which affects the way in which research is set up, the treatment of the participants and the conclusions drawn. A feminist interpretive stance assumes the engagement of the researcher. Importantly however it also assumes the obligation of the researcher to recognize and acknowledge her own position. Rejecting the claims of objectivity does not release the researcher from the responsibility for faithful representation of what is being studied. "We may not rewrite the other's world or impose upon it a conceptual framework that extracts from it what fits with ours. Their reality, their varieties of experience, must be an unconditional datum. It is the place from which enquiry begins" (Smith, 1990, p.25).

Institutional ethnography

The particular research approach developed by Smith is known

as "institutional ethnography". Smith (1987):

> uses the terms "institutional" and institution" to identify a complex of relations forming part of the ruling apparatus, organized around a distinctive function - education, health care, law, and the like (p.160).

Smith developed her research approach as a way to explore the particular needs of women in what she sees as a socially constructed world. Smith (1987) argues that "the only way of knowing a socially constructed world is knowing it from within" (p.22). The idea of knowledge from within stands in opposition to the idea of knowledge from an outside, objective, stance. Logically, then, Smith's enquiry begins from the standpoint of women, but the essence of her approach is the analytic movement from the place of women, the experienced or everyday (the local), to the extralocal conditions which shape it. "We cannot find the inner principle of our own activity through exploring what is directly experienced. We do not see how it is put together because it is determined elsewhere" (p.27). Smith discusses Harding's (1986) contention that feminist research should repudiate the notion that a master narrative is possible. Smith does not challenge the concept of "multiple partial knowledges" (p.34) but in her view there is a

difference between the idea of an enquiry which seeks to establish a definitive truth and an enquiry which seeks to discover how the everyday world works. This discovery of "how things work, how our world is put together, how things happen to us as they do" (p.34) is at the heart of Smith's research. Indeed Smith sees this discovery as essential for women because "if we don't examine and explicate the boundaries set by the textual relations of ruling, their invisible determinations will continue to confine us" (p.65).

Campbell and Jackson (1992) describe institutional ethnography as a method "in which the talk and action of individual actors are examined as traces or points of entry to the larger social process by which they are shaped and on which their sense and rationality depend" (p.476). I understand the approach to rest on three key assumptions. (1)Knowledge is socially constructed, (2)in our society much of what we know is textually mediated, by and for ruling purposes and (3) there is a disjuncture between everyday practices and how the world is understood from the texts which purport to speak of, or represent, the everyday.

Smith (1987) uses the term "line of fault" to describe this

disjuncture. It is critically important to her method of enquiry because it becomes the entry point for the researcher's exploration. Institutional ethnography begins with the standpoint of an individual and moves backwards to trace the extra-local organization of the everyday experience. Understanding the use of an individual standpoint is important for my data analysis. In a discussion of the use of her methodology Smith (1987) addresses the issue of "generalizability", a notion usually tied to questions of sample size and validity. According to Smith institutional ethnography begins with the understanding that:

> [an] ordinary daily scene, doubtless enacted by many in various forms and settings, has an implicit organization tying each particular local setting to a larger generalized complex of social relations (Smith 1987, p. 156).

The aim of institutional ethnography is to explicate the relation of the local and particular to the generalized social relations. In this way, Smith explains:

> The particular "case" is not particular in the aspects that are of concern to the inquirer. Indeed it is not a "case" for it presents itself to us rather as a point of entry, the locus of an experiencing subject or subjects, into a larger social and economic process. The problematic of the everyday world arises precisely at the juncture of particular experience, with generalizing and abstracted forms of social relations organizing a division of labour in society at large (Smith 1987, p. 157).

In Campbell and Jackson's (1992) account of learning to

nurse there is a disjuncture between the work of being a student nurse and the experience which enters into the records. The experience of the student directs the enquiry to ask how the "work" is organized and what is involved in determining the form of the textual account. "What is the purpose which the account serves?" "Who benefits from the account and in what way?" are questions whose answers link the student to the wider social relations of the academic and health care systems. We see professional and educational standards and requirements organizing the instruction and students being prepared to operate in organizations managed in particular ways.

In the Comox Valley I saw a line of fault between the Nursing Centre project as described by the RNABC, and as it was experienced by the Comox Valley nurses. My study represents only a segment of the RNABC's Comox Valley Nursing Centre Project. It is a segment which seeks to take the experience of Comox Valley nurses as a point of entry into the institutions of health care and professional nursing. The experiences of individual nurses are used to identify useful explorations into the extra-local coordination of nursing work. These explorations and my analysis are used to explicate the work of the nurses in the

Comox Valley and, at the same time, identify questions which move beyond the scope of my study.

In the study cited above, and in other work, Campbell (1988,1992,1994) has written extensively on the question which forms the sub-text of the Comox project: "what holds nurses to certain forms of action?" (1994 p.6). Her work indicates that the answer goes beyond an understanding of the stereotypical doctor-nurse hierarchy. The way in which nursing practice is constructed is linked to the way in which nursing enters into a form of textual relations. George Smith's (1990) account of an institutional ethnography details the importance of text as a coordinator of activity: "texts as active constituents of social relations can iterate the particular configuration of their organization in different places and at different times, thereby conceptually coordinating and temporally concerting a general form of social action" (p.636). Smith is explaining the feature of textual "action" that makes it useful for managing or ruling. That is, recording makes action transpersonal. Words speak in the absence of the speaker and different people across various sites can thus understand the same things. Campbell (1994) discusses the "increasing importance of documentary or text-based action,

as opposed to direct or hands-on action in health care" (p.1) Key to both Campbell's and George Smith's argument is the understanding that exploration of the coordinating properties of texts and of textually based relations leads to an explication of how everyday life is organized. My research seeks answers to how the Comox project is organized so that choices about evolving practice can be understood.

The study

The particular interpretive stance required by institutional ethnography produces a method of enquiry which is determined by the work itself. Smith (1987) explains the use of the techniques of institutional ethnography as follows:

> ethnography commit[s] us to an exploration, description, and analysis of [institutional] relations, not conceived in the abstract but from the entry point of some particular person or persons whose everyday world is organized thereby (p.160).

My experience with the Comox Valley Nursing Centre is described below.

My initial exposure to the Comox Valley project occurred in February 1994 when I accompanied members of the evaluation team to Comox for two days of interviews with local participants in the project. The goal for the evaluation team was to gain an update in the progress of the project's

implementation. During the two days we met individually, and in groups: local nurses working as volunteers on the project; the one paid local nurse working as the implementation coordinator; and members of the local community who were interested in the project.

This data provided me with an entry into the complex process by which the RNABC was attempting to implement "nursing" in a new community setting. The questions which arose from this visit directed my attention to the planning and implementation process and the relationship which the process was establishing between the RNABC, local nurses, and interested residents of the Comox Valley area. Using interviews and observational techniques, I gathered stories of local participants and explored ways in which these stories could be understood by examining the extra local coordination of nursing - and thus the project - through the agency of the RNABC.

My study covers the final months of planning and the first six months of the Centre's operation, a period of ten months from February to November of 1994. I entered the project as the planning phase neared completion, and my data collection ended six months after the Nursing Centre opened its doors.

The Nursing Centre is the subject of a large and complex evaluation process which will examine the project in its entirety. My work reflects the period I have identified and my analysis is based on the experience reported by the nurses at that particular time. As the planning period ended and the Centre staff were hired my attention was directed to the nurses who would work in the Centre. I visited the Centre for several days on three additional occasions: early May, late June and mid November of 1994. During these visits I spent time with Centre staff in order to gain an understanding of their everyday world. I interviewed the five nurses, observed their interaction with clients both individually and in a group setting, and examined documentation of the Centre's work. In addition, I was able to join members of the evaluation team and Centre staff in a discussion of charting, in a meeting with the Community Advisory Committee, and a meeting with the Nursing Practice Council. I made extensive field notes of these meetings and interviews, and I had access to the tapes of the meeting between the Centre staff and the evaluation team in June of 1994. The nurses' stories, and my observation of their work led me to an extensive review of nursing as it appears in the official texts of the RNABC publications. The documentation I analyzed helped me to make sense of the

nurses' talk about their experience. The line of fault which emerged, that is, the discrepancy between the world of nursing as reported by the RNABC and the experience of the nurses in the Comox Valley Nursing Centre, is discussed extensively in the chapters of data analysis.

My work is not an evaluation of the Nursing Centre, although as a nurse and a researcher I draw inferences from my analysis. Rather my study seeks to examine how nurses are inextricably linked to the health care delivery system and how this system works to maintain the current hierarchial status of the institution of health care in British Columbia. As a starting point I listened to how the nurses talked about what they know and I assume that they are telling how it is for **them**, that is neither right nor wrong, but an account of their understanding. From my stance as a researcher, aware of their world but distanced, I looked at how their understanding is linked back to the larger social structures of health care. So, for example, when the nurses struggle to identify clients in terms of 'problems' to be resolved I looked at how nursing is organized in ways which direct nurses to consider their clients in this particular way. Institutional ethnography does not seek to generalize or to imply a prediction based on cause and effect. Rather

it seeks to show how things happen.

Before beginning the data analysis, I will outline a history of the Nursing Centre project in the next chapter.

Chapter Three - Policy into Practice: A Nursing Project

Before addressing my research question specifically, I provide in this chapter an overview of the larger context of my study, a history drawing on project papers to which I have access through permission of the evaluation team, my own field notes, and material published by the RNABC.

New Directions - The Policy Context of the Nursing Project

During the late 1980s and the early 1990s the RNABC engaged in a series of actions to establish nursing as a key stakeholder in the redefinition of health care and health care delivery. Among other initiatives, the Association produced a number of publications under the general title New Directions for Health Care. These publications described and supported a policy position taken by the RNABC encompassing a vision for health care supported by a series of discussion papers which explored the potential role for nursing in the newly envisioned health care program in British Columbia. The work provided the RNABC with an excellent foundation and framework from which to respond to the provincial government's Royal Commission on Health Care and Costs. The RNABC, on behalf of nursing in British Columbia, submitted forty separate recommendations to the Commission in three general areas: primary health care; health care finance; and nursing care (RNABC 1990b).

Of particular interest for my study was the RNABC's policy position which established their intent to promote a larger role for nurses in the utilization of health care resources and, by implication, capture a larger share of the health care resources for the profession. In 1992 - 1997 A Further Five Years: A Plan for Action (RNABC 1991) the Association states that goal three is "a nurse influenced health care system" (p. 8). The paper notes that the RNABC should:

> consider ways to assist nurses to more effectively assume an influential role in future health care planning at the agency and community levels. Finally the Association should renew and increase its effort to present nurses and nursing as positive forces, which are critical to an effective health care system at both the planning and delivery levels. The general public media should be a major target for this effort. (p. 8)

Attridge (1993), in the evaluation proposal for the Nursing Centre project notes "it is a chaotic period for health care in this province and in the country". This perspective is echoed by Rachlis and Kushner (1994). In their analysis of problems of the Canadian health care system they argue that:

> What really needs fixing is the unplanned, uncoordinated, and unaccountable way we deliver health care (p. 3).

The RNABC'S proposal to test an alternate form of health care delivery fits well into this political context. It is in a sense a window of opportunity for nursing. The Association took advantage of this opportunity and,

following negotiation with the provincial Ministry of Health, the RNABC received funding in the amount of $385,000 for a nursing demonstration project to be implemented over a two year period.

Funding for the project was announced by then Minister of Health, Elizabeth Cull, at the RNABC annual general meeting in April 1993. The timing of the announcement went without remark. It is not unusual for political figures to make funding announcements at media appearances and Ms Cull was a keynote speaker at the RNABC meeting. The specific political implications of the funding decision are not a subject of my study, nevertheless some comment on the implications of the initial announcement are relevant to the direction taken by my analysis, and are discussed below.

Subsequent to the annual general meeting the RNABC began the process to select a community for their project, this is described by Attridge (1995):

> RNABC then embarked on an extensive process through which, in brief, the project was publicized, criteria were developed for the selection of the community site, applications were made whereby communities demonstrated how they saw themselves meeting the criteria, and a community was selected on the basis of the quality of the community applications as assessed through the criteria. Eleven communities applied, and after an extensive selection process, the Comox Valley community was chosen (p. 4).

This application and selection process is described by

Attridge as "extensive" and by RNABC project worker Heather Mass as "arduous" (Victoria Chapter meeting May 1994). Of interest to my study was the RNABC's decision to establish a time frame which effectively set another, unofficial, criterion that is, the availability of nurses able and willing to volunteer their time during the peak months of summer. Here in the inception phase the RNABC unwittingly failed to recognize nurses as women with lives and families outside the domain of nursing. As I will show in my study the recognition of volunteer time became an issue during the implementation of the project.

Comox Valley - the chosen site

The RNABC selected three potential sites for the project as a short list and these, together with the Association's recommendations were forwarded to the Ministry of Health for final selection. The Comox Valley nurses were notified of their selection at an RNABC chapter meeting on September 16th 1993. My data collection begins in February 1994, as the RNABC began to integrate local community representatives into the planning process. I will now describe the background to this period and the organization of the various committees which are referred to in my data.

My information for this period is drawn from recollections

of the nurses involved, from RNABC material, and from members of the evaluation team.

Infrastructure

Within the nursing community in British Columbia the Comox Valley has a reputation as a strong nursing area. The local participation by nurses in community events and RNABC activities is perceived to be enthusiastic. This perception was reinforced at the beginning of the RNABC project. One hundred and thirty nurses attended a meeting held in Comox to begin the planning process for the Nursing Centre Project. This commitment was important to the success of the project as the early work was almost entirely based on donated time.

A project steering committee and various sub-committees were formed by the local nurses under the general guidance of Heather Mass, an RNABC staff member. In addition, the RNABC recruited one local paid project worker to act as a liaison between the community and the RNABC, and to be a resource for local volunteers. There was no clerical support available and, initially, no office space. In December the local municipality offered the nurses use of an office in the recreation centre. This was a very small space situated at the far end of the weight training room (and housing the

music system). It was not suitable for meetings and the committees made use of their own work places and homes. The nurses donated countless hours of time to the project. Nevertheless, at times personal commitments and crises intervened and the work of planning moved slowly over the initial months of the project (Field notes, February 1994).

Workplace Rules

In addition to the difficulties of coordinating a large scale volunteer project, the RNABC faced some unanticipated workplace troubles. Specifically, the British Columbia Nurses' Union (BCNU) insisted that staffing positions in the Nursing Centre be unionized. This insistence had an influence on the development of job descriptions. Initially, the RNABC had intended to require baccalaureate preparation for the staff positions. However, following discussions with the BCNU, neither the coordinator nor staff nurse positions required advanced educational preparation (Field notes February 1994, Job Descriptions). This seemingly small disagreement reflects an area of contention between RNABC and the BCNU. While RNABC links the notions of advanced education to professional gains for nurses, the BCNU points to large numbers of working nurses currently prepared at the diploma level and facing potential limitations to their career choices. One of the goals of

the Nursing Centre project is to explore how nurses might best be prepared to move from hospital based practice to the Association supported community oriented model. The BCNU at this time was concerned to ensure that the process took the current standard for entry to practice as a beginning point. As it transpired staff who were hired to work in the Centre covered the entire continuum from diploma preparation to Masters of Nursing.

The BCNU also raised the issue of employer/employee relationships. The RNABC does not have a mandate to operate health care facilities and could not stand as the direct employers of the Centre staff. To circumvent this problem, and to accomplish union membership, Centre staff were technically employed by the local hospital in Comox, St Joseph's. The hospital maintains the staff's work records and issues their pay cheques, providing this service, as a goodwill gesture, without fee. However, the staff report to the RNABC in the person of Heather Mass.

Staffing

The costs of the entire project, including rental space, supplies and staffing, is provided by the Ministry of Health. Budget for staff was thought to be minimal and some creative arrangements were undertaken to stretch the funding

over as many staff as possible. The budget developed by the RNABC anticipated a staffing level of three full time equivalent positions. This staffing budget was operationalized as one coordinator hired on a full time basis, with the remaining two positions divided into four part time positions. This strategy was expected to maximize the somewhat small resource pool available. A staff of three full time equivalents limits the coverage which can be offered and various sets of operating hours were tried as the nurses attempted to determine what best met community needs.

The staffing budget also provided for four hours of receptionist time, five days per week. This was supplemented by community volunteers acting as welcomer and telephone receptionists. The volunteers also provided a much needed safety back up for the skeleton staffing. In the early days of the project there were times when the schedule assigned only one nurse on duty, raising concerns for the nurses' personal safety. One of the ways this was addressed was to designate these periods as priority volunteer assignments to ensure the staff member would have back up.

The nurses had a scheduled rotation for their days off but

in practice they disregarded this in order to accommodate the needs of their clients and the demands of the development work they undertook. Working on weekends and in the evenings at community centres, malls, and at meetings of various volunteer agencies, they attempted to establish the Nursing Centre as part of the local service agency network.

Extra-local co-ordination

The influence of the RNABC is a major topic of my data analysis, however the Association's overt presence decreased following the Centre's official opening in May 1994. During the planning phase the Structure Sub-committee developed a coordinating model to integrate community representatives, local nurses, and Centre staff. Essentially the model consisted of two ongoing committees, the Nursing Practice Council and the Community Advisory Committee. Structurally these operated in a matrix fashion and were intended to assist in the coordination of the clinic's activities. Both were charged with advisory roles and the staff's overall accountability remained with the RNABC. However, as my data shows, the committees exercised an influence over the Centre's work.

This overview is necessarily brief, and the questions raised by this project are numerous. For the remainder of my

thesis I turn to my data and the analysis I made to explicate the puzzles I selected to address, namely the relationships and structures which emerge through the implementation of this project and the ways in which nurses' work is organized and accounted.

Chapter Four

Construction of a project: the RNABC implements a Nursing Centre

In this chapter I look first at the governance of nursing in British Columbia and at the mandate of the RNABC. I show how the RNABC has adopted the idea of Primary Health Care as a way to meet part of the Association's mandate and I argue that the RNABC is attempting to use this concept as a way to enhance the status of nursing while avoiding any direct role confrontation with physicians. I then examine the way in which the RNABC planned to develop a setting for nursing, the Nursing Centre, and I make the following argument: contrary to the stated goal of providing an environment for nurses to create a new form of practice, the project created an environment that initially hindered this goal. Development of the Nursing Centre, as the RNABC envisioned it, created tensions and negatively impacted the community partnership which was intended to be integral to the project. In the initial stages, nurses were required to work, as they already know how, in a managerial and bureaucratic way; conversely, the community development ideas reflected in the project description are not a regular part of nursing knowledge, nor of the RNABC's managerial approach. Lack of congruence between the two approaches,

organized from the top down, that is through RNABC rules and expectations created a non-harmonious basis for the Centre and thus, I argue, hindered the development of any new way of approaching, or valuing, nursing work. An analysis of the mechanisms of bureaucratic work sheds light on how this style of management exerts unseen control.

Setting the direction - organizing nurses in British Columbia

The RNABC fulfils its mandate to regulate nursing in a particular way, employing organizational structure and practices that, as we shall see, train nurses in how to act organizationally. The RNABC's publication Nursing in the Public Interest (1994a) states that the association is entrusted:

> with the responsibility for establishing, monitoring, and enforcing standards of education and qualifications for registration; promoting high nursing practice standards; monitoring and enforcing professional ethics; and reducing incompetent, impaired or unethical nursing practice (p.1).

In order to fulfil this comprehensive mandate the Nurses (Registered) Act, and the Association's constitution, establishes a governance structure of working committees under the authority of a board of directors. The Board consists of sixteen officials elected from the Association's membership and eight public representatives appointed by the Minister of Health. The Board administers the business of

the RNABC through a staff of paid professionals including nurses, policy analysts, legal advisors, researchers, and so on. Funding for the Association comes from mandatory membership fees. Members have an opportunity for input through their elected officials. The RNABC operates as an hierarchial organization with a bureaucratic management style. That is, it has the characteristics of a bureaucracy as described in standard management texts: "division of labour, a clearly defined hierarchy, detailed rules and regulations, and impersonal relationships" (Robbins and Stuart-Kotze, 1986, p44). I will return to the implications of this organizational format after examining the goals or duties of the RNABC in respect to regulating nursing.

While the Nurses (Registered) Act provides a legal statement of the Association's duties the interpretation of how its responsibilities are carried out changes over time. This section discusses some of the contemporary issues that are contributing to a more assertive stance by the RNABC on what the nurses' role should be. The Nurses Act states that:

> It is the duty of the association at all times
> (a) to serve and protect the public, and
> (b) to exercise its powers and discharge its responsibilities under all enactments in the public interest. (Nurses (Registered) Act, section 38, 2.1)

This form of wording is common to all self regulatory legislation and the RNABC gives a fuller meaning to the

association's purpose in the constitution. Article 11 states:

> The objects of the Association include the following:
> a. to further the standards of nursing practice and education in order to achieve effective and efficient service to the people of British Columbia;
> b. to uphold the integrity of the nursing profession and support its contributions to the health and welfare of the people of British Columbia. (RNABC constitution article 11, 1994)

These notions of "effective and efficient service" and nursing's "contributions to health" are important in the context of health care in the 1990's and the climate of cost effective health care. Although carefully framed in public service language the RNABC clearly also promotes the interest of its members. In the early 1990's the Association took a proactive approach, specifically seeking to enhance public awareness of, and appreciation for, nurses' contributions to health care. The Association developed a policy initiative entitled "New Directions in Health Care", a key feature of which is to "demonstrate and make more visible the special contributions of nursing to health care" (RNABC, 1990a, p.6), especially in the changing context of health services delivery.

The status enhancing goal, identified above, is part of the RNABC's vision of health care which is firmly allied to the

concept of primary health care. For example: RNABC is firmly behind the international movement to "achieve health for all" and believes primary health care is the means to achieve this goal" (RNABC, 1990a, p.i).

Primary health care is a term which was essentially coined at the World Health Organization conference in Alma Ata in 1978. The WHO definition of primary health care is:

> Essential health care universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community can afford. (RNABC, 1990a).

The ideas expressed by the WHO description have been widely linked to health promotion in third world settings; immunization projects or water and sanitation initiatives are examples. More recently however, nursing organizations in the industrialized world have seized on primary health care as a vehicle to promote nursing. Specifically, organized nursing, along with a number of other health professions, promote themselves as ideally suited to provide the first point of contact for much of "essential" health care, making referrals to secondary care providers as needed. Arguments supporting these proposals utilize the current climate of cost restraint, claiming that nurses can offer this service in a more cost effective way than the existing system. The Canadian Nurses Association (CNA) states:

"nurses are ideally positioned to be major players in improving the cost effectiveness of our health care system" (1993, p.3). In the same publication the CNA reviews a number of nursing initiatives and reports:

> A study in Burlington Ontario showed that specially prepared nurses could provide community health care normally done by higher cost doctors. Additional analysis of these results concluded that 20% to 30% of the work of general practice physicians could be replaced by nurses over a twenty year period. (ibid p.11).

This view is at least partially shared by the RNABC, which also envisions a future of community based health centres in which nurses will function in advanced practice roles as points of entry into the health care system. In the Association's publication Primary Health Care: Answering Nursing Practice Questions they state: "as care providers, there will be an increased need for nurses to function in advanced practice roles as **point of entry** to health care" (1992a, p.20 bold face emphasis added).

The relationship between the Nursing Centre project and the RNABC's vision for nursing as articulated in the Association's publications is important as it provided the context in which the nurses might do this new primary care work. A paper on Nurse Practitioners prepared for the provincial Ministry of Health explicitly separates the concept of "advanced practice" from the job title "Nurse

Practitioner". The authors (Henning and Cox, 1994) argued that nurses already demonstrate an ability to meet a huge variety of health care needs. Henning and Cox point out that much of this ability is currently under-utilized. It is interesting to note how the discussion in the Henning and Cox paper is an attempt to defuse the almost automatic reaction by physicians to any attempt to introduce alternate ways in which nurses can work within health care delivery systems. Henning and Cox recognize the lack of support from organized medicine for an independent nursing role and go on to note that:

> It again needs to be stressed that to appropriately utilize nurses, is not an effort to replace physicians but rather to be complementary to physicians and other health care professionals to fill current gaps in health care (Henning and Cox, 1994, p.5).

The RNABC has taken a similar approach in framing the Nursing Centre proposal. The Association avoids any direct challenge to physician practice and speaks only of enhancing the scope of nursing. Here we see the window of opportunity being created for an enhanced nursing practice role. It appears that the RNABC seeks to explore the idea of primary care and enhanced nursing practice through the vehicle of a community project. "Gaps in service" which are thus identified can then become the domain of nursing. Although direct challenge is avoided the implications of this

approach are not lost on physicians. This aspect of the project is discussed in chapter six.

Demonstrating nursing as community service

Faced with the task of implementing a nursing centre as a community project, the RNABC confronted a major problem. The community project assumes a different role for nurses than the general public expects them to play. The public's view of nursing has never been completely congruent with the RNABC's ideas and nurses as primary care workers is a new concept. Previous experience had shown that community members are not likely to see nursing as a valuable community resource. In a previous project sponsored by the RNABC, the Little Mountain Riley project, area residents failed to identify nursing as a community need. To address, in advance, any repetition of such a problem, the RNABC guided the Comox project in a direction that, I argue, had significant impact on the ability of local nurses to establish themselves as proactive health care leaders. In attempting to find a solution to this potential problem the RNABC sacrificed its commitment to community participation in favour of a project implementation plan which privileged the views of a group of participating nurses who themselves were acting under the aegis of the RNABC.

The RNABC did not specifically claim that the Nursing Centre was to be a community development project. Indeed I see that the planning and implementation process could best be considered to fit Labonte's (1993) description of community **based** programming in which decision making power rests with the institution and the "problem" is named by the institutional participants. At the same time the RNABC made use of language which implies a community **development** process. As described by Tate (1993) in a paper on community development and nursing, the characteristics of community development include: citizen participation in planning, decision making, and action; involvement of those most affected; bridging of diverse community interests; emphasis on the link between social/economic/environmental aspects of community life; and is not limited to a single issue or interest area. According to Tate "facilitators of a community development process do not predetermine the outcome and are open to surprises" (p.3).

As I will show, this confusion about the Project's grounding assumptions by community participants together with the firm guidance given the project by the RNABC led to difficult relations in the community.

A nursing plan

The RNABC established a planning phase which, initially,

severely limited community input and was linked more closely to the Association's concern to promote nursing. Speaking at a meeting of the Association's Victoria Chapter (June 10th 1994), an RNABC project director, Heather Mass, described how the process had been determined:

> Because nursing is invisible to the community RNABC felt that a conventional community development process would not lead to the community identifying "nursing" as a need - see for example the Little Mountain project - they proposed therefore a nursing centre to be trialled in a host site which would allow RNABC to achieve **their** goals. (notes taken at presentation cited above, my emphasis).

To achieve their goals, the RNABC implemented a strategy that violated an authentic community development process by pre-determining nursing as a community need. They then widened this break by deciding to establish what were essentially nurse-only committees to do the work of the early stages of the planning process. The RNABC's decision to exclude the community from the early phase of the project established an environment in which "nursing" and "the community" evolved their ideas about the Centre along separate paths.

The time lines laid out in the project background paper established a two year timetable for the project:

> The project will be carried out over a 24 month period with the nursing centre opening in the sixth or seventh month and the remaining time being used to implement the model and evaluate for economic and health benefits (RNABC's Nursing Centre Demonstration Project, 1993).

To facilitate the nurse-only work Heather Mass established a planning structure and process consisting of a steering committee and task oriented sub-committees. The steering committee contained a single community representative, an individual who had previously served as one of the lay members of the RNABC Board. The membership of the other committees consisted of nurses living in the Comox Valley.

> On October 7, 1993, a Nursing Centre Steering Committee made up of nurses and a community volunteer was formed in the Comox Valley to begin planning for the Project. Sub-committees were also formed to plan various aspects of the project including community liaison, support structure, programs and nursing model, local evaluation, communications, and community health needs. (RNABC publication Update: One Year After 1994b)

At the completion of the nurse-only work, two permanent committees were established to guide the project to completion. One of these is explicitly "community", the Community Advisory Committee (CAC) and the other is explicitly nurse oriented, the Nursing Practice Council (NPC). The Terms of Reference for the two committees show some overlap; both speak of "advising the coordinator" and relate to strategies for providing nursing services to the community. Nevertheless, while the CAC speaks of "increasing the coordination and integration of health services" as an objective, the NPC is directed toward developing the role and function of nursing, and is explicitly directed to "ensure professional standards of

Nursing Practice are maintained within the nursing centre" (Terms of Reference, CAC and NPC May 1994). While nurses sat as equal participants on the CAC there is no reciprocal community representation on the NPC. I see this structure as an instance of an understanding of "nursing" as separate and distinct, i.e. expert and professional, rather than a collaborative partner in the health of a community. The wording of the two sets of terms of reference establishes the work of nursing outside the domain of the community. This concept is closely linked to the notions of professionalization and privileged knowledge, but runs counter to the goal of increasing the general community's understanding of nurses' work. The ways in which this separation of "community" and "nursing" became a factor in the Comox Valley project are discussed below.

The plan in action

Nurses are familiar with committee systems as part of their work process, both in hospitals and in the organization of their professional Association. The project's planning process, outlined by the RNABC, was accepted as a familiar and appropriate manner of work. In February 1994, I visited the valley with two members of the evaluation team and participated in their interviews with local nurses who had worked as members of the various committees. This committee

participation by the nurses was performed on a volunteer basis. The stories of committee work performed by the nurses of the Comox Valley, revealed both their commitment to the project and the emotion they had invested in it as the following example demonstrates:

> Late in the afternoon of the first day we met with [nurse]. The meeting had been set up initially to get her feedback on the work of the committee she chaired. However! It transpired that she was one of the two nurses present at the community meeting last night and she talked mainly of that experience. She expressed a lot of frustration and perceives that the community have not recognized the sheer amount of work the nurses have done to date - she spoke of "nurse bashing" at the meeting last night and at one point today she was in tears. (field notes from February 1994).

This was one graphic instance of the nurses' troubles and frustration that can be seen as outcomes of earlier planning, coordination of activities, and control exercised as by the RNABC. It could be said that those plans which separated nurses and nursing from their community constructed the community and nursing as separate groups with separate ways of thinking about the project. How did this happen? Next I turn to analysis of data that provides glimpses into this process of construction.

It is my argument that the plan outlined by the RNABC, and the committee structure proposed, established a pre-understanding of committee work based on a model of program implementation outlined by the RNABC. Consider, for

instance, this founding assumption:

> Phase 1 will see the development of a Nursing Centre Plan by the Nursing Centre Planning Group. This will require introducing the concept to the community at large and to other health care providers..... (RNABC, 1993, p.8).

In other words, although the RNABC spoke of the project in community terms their implementation process did not reflect a community development approach. Rather, the procedure the RNABC set out for the nurses replicated the Association's standard bureaucratic manner of practice with a series of task specific sub-committees. This conventional manner of working, which promotes division of effort, makes holistic conceptualization of a project difficult if not impossible to achieve.

Retrospectively nurses in Comox described the difficulties of the planning phase as "confusion", attributable to the lack of a "master plan" (Cadden, 1995, p.32).[1] What is not identified by Cadden, nor apparently seen by the nurses is the way in which the process managed by the RNABC controlled the way in which the project could evolve. The formal bureaucratic structure of the planning process mirrors the ways in which nurses normally work in hospitals and in the RNABC. This process, however, runs counter to community development approaches in which planning begins at the grass

[1]A member of the Nursing Practice Council writing in the R.N.A.B.C.journal

roots level. The usual approach to community development is a strategic choice that aims to transfer power and control to the community.

Bureaucracy in action

I argue that the management style of the RNABC, rooted in a bureaucratic model, exercises a control which is masked by the prevalence of this manner of organizing work. Franklin (1990) points out that:

> The acculturation into a culture of compliance built on the willing adherence to prescription and the acceptance as normal of external control and management make[s] bureaucracy possible (p116).

The acculturation into bureaucratic modes of organizing of which Franklin speaks is a relatively modern phenomenon. Ferguson (1984) ties it to the last one hundred years and she describes bureaucracy as both a structure and a process. Understanding this dualism sheds light on the ways in which a bureaucratic system is experienced in everyday work. In an extensive study of the evolution of modern management systems Yates (1989) describes the emergence of technical control:

> As business struggled to acquire, record, and disperse data and decisions, a rising tide of technical and organizational innovations appeared, all designed to improve communication and control in complex organizations. (p.xi).

The emergence of modern bureaucracy is linked historically with the emergence of a specific form of management

technology known as scientific management. The technical innovations of scientific management were adopted by both private and public agencies. The components of bureaucracy identified by Weber: division of labour;authority hierarchy; formal selection; formal rules and regulations; impersonality; and career orientation (Robbins & Stuart-Kotze, 1986, p45) are complemented by ideas underlying scientific management:

> That social efficiency is the analogue of machine efficiency, and that the appropriate social order mimics the internal organization of machinery - designed by experts according to a pattern of minute specialization, rigid hierarchy, and absolute control (Merkle, 1980, p.81).

According to Merkle (1980), the ideas underlying scientific management are amongst the "most pervasive and invisible of the forces that have shaped modern society" (p.3) The engineering model, transferred to systems of administration and government, produced paper flow systems analogous to systems of machinery. More importantly it produced a pervasive acceptance of the rational and the objectively measured as cornerstones of social organization. Franklin (1994) describes these as "prescriptive technologies" and she notes:

> After the industrial revolution, when machines began to be added to the workforce, prescriptive technologies spread like an oil slick. And today the temptation to design more or less everything according to prescriptive and broken-up technologies is so strong that it is even applied to those tasks that should be conducted in a holistic way (p.24).

Control through this form of management has two aspects. The first is the development and use of specific management technologies: methods of organization, accountability structures, and development of objective and depersonalized forms of evaluation. The second aspect is the training of people to use these methods, that is, to see their work in systematic terms.

Campbell and Jackson (1992) offer insight into how nurses learn these kinds of practises in contemporary nursing education. These practises are unofficial yet central parts of the educational process preparing nurses for their day to day work in objectively organized and managed health care agencies. In Campbell and Jackson's study the work of the student nurse is organized by a specific nursing model:

> The model provides a method of subsuming the specifics of each situation to fit the available repertoire of problems for nursing intervention. In the process the categories of the model tend to become objectified, and the real world becomes a resource to satisfy the requirements of the model rather than the other way around. (p.485).

In this instance, the student is being directed, not only to learn the principles of a specific model, but to account for her work in a specific and objective form, and in doing so to meet specified standards which have been established outside the working context.

In this way, Campbell and Jackson argue, the nurses also learn to separate themselves from the work they perform. Individual attributes which they bring to their work have no place in the categorization of nursing interventions Their behaviours are expected to conform to what are perceived as professional expectations. Nurses are learning what Ferguson (1984) calls "the cult of rationality" in which the personal and idiosyncratic subjective voice is subjugated to the requirements of the official stance. This is a source of disjuncture for nurses who work in a system in which the purportedly valued qualities of caring, empathy, and compassion are compelled to exist within systems and processes which place value on the objective and the rational.

Planning together - integrating community and nursing

In the Comox Valley Nursing Centre the RNABC attempted to utilize a prescriptive systematic technique to develop a community project. The difficulties they faced when they tried to bring the community on side are expressed by one of the local residents, a woman with previous community development experience. She noted:

> My perspective? I think the RNABC wanted to demonstrate a pilot of [nurses] doing nursing - they could have just set up a centre but they chose to involve the community. They [the local nurses] are doing a great job but they are not trained to do community development - and its not something you can

do without training. (Field notes Feb. 1994).

This understanding was unfortunately not prevalent amongst either the nurses or other community members. In the discussion which follows I argue that the hegemony of bureaucracy is implicated in the relationship which developed between local nurses and community members involved in the project as they began to try to work together.

From a nursing perspective there were some positive aspects in the initial planning period. For example, this nurse's comment about the benefits of networking with other nurses was echoed by many others, she notes "we've learnt so much - how can it be a failure, even if it ends tomorrow. (Field notes February 1994) The value this nurse placed on the process is related to the discussions with colleagues and the increased awareness created when local nurses shared information regarding their various disparate roles. The planning process provided the Comox Valley nurses with the opportunity to come together and share their experience of work: in the community; in mental health; in continuing care; in acute care; in education; and at all levels of nursing practice. However, this benefit was visible only to the nurses themselves. Members of the community were excluded from this part of the planning process and thus had

no opportunity to gain insights into the working world of nurses. In addition, members of the community who did become involved in the project and who became members of the CAC were themselves, for the most part, also used to working in a bureaucratic fashion; that is they were, like the nurses, inexperienced in community development. The group included retired administrators, civil servants, seniors' housing administrators, a hospital based pharmacist, and so on.

As I have indicated neither nurses nor community members had a clear idea of how to develop the project in a community development or even a community-based way. Instead the nurses recognized that the planning process had established an expectation that the nurses would have a plan to present to the community and indeed the RNABC background paper had suggested that the initial phase would produce a detailed plan. Consider this excerpt for instance:

> The nursing centre plan will detail the management structure; the funding sources; the accountability mechanism; operational details such as location, staffing, and hours of operation; services/programs and proposed health outcomes; evaluation targets and methodology; relationships with other health care providers/agencies (RNABC, 1993, p.8).

The nurses' concern - to realize this plan - is reflected in a discussion with one of the nurses in February. My record of the conversation between the nurse and members of the

evaluation team is noted below:

> "Final reports from the Committees [the Sub-Committees] are in - some are not well written, the recommendations are not clear. The idea is to pull all together to a final 6 - 8 page document" [nurse] seems concerned about the general standard of work and believes the reports may be ignored due to poor readability. [nurse] quoted one sub-committee chair person as delivering a final report and saying "this is as good as its going to get" (Field notes February 1994).

The nurses' concern was well founded in that the community members were unhappy with their exclusion from the initial planning process and thus were disposed to be critical of the nurses' work. As late as June 1994 their exclusion was still identified as an issue. In a meeting with members of the CAC, my notes indicated that this was almost the first point brought up, and that it was "clearly still a sore point" (Field notes June 1994). So, it appears that the strategy chosen by the RNABC to promote the Nursing Centre backfired. It put nurses in control of the process but it created tension. The failure of the RNABC to adequately address this tension during the planning phase contributed to the ways in which the community would or could come to understand nursing, and to work cooperatively.

Controlling the plan

When the RNABC did begin to introduce community representation into the project, the Association gave a confused message to both the community members and to the

local nurses. Comments from members of the community in February make it clear that they (the interested residents) saw this as a community "owned" project and were interested in assuming an active management role. In response to question asked by the evaluation team, "who should own the project?" one community member responded "It's a community facility and belongs with the community - there could be some sharing of control and nurses should have the final decision on money but the advisory [CAC] should oversee it. (Field notes February 1994). But this was not to be. During this period it was made clear to Valley residents that the RNABC retained control, and that neither the local residents nor the local nurses had the authority to make significant decisions. One anecdote from this period captured this:

> At last week's community meeting the local residents put forward a concern about the name of the project - they felt that Nursing Centre was not in tune with the concepts of health and wellness being promoted and they wanted to name the Centre the "Health Centre". The local nurses working on the project have been taking it in turns to attend the community meetings and the two present were caught by surprise - they indicated that the meeting did not have the final say on the name and suggested that the RNABC would need to be contacted. There was apparently some confusion around contacting the RNABC because Heather Mass was away but the end result is that the Association has not given approval for a name change. (Field notes February 1994).

The attempt to marry a participatory strategy with the management format of the RNABC led to a decision making process which was unclear and cumbersome at this time in the

project. As a result of this lack of clarity a misunderstanding developed between the members of the CAC and the local nurses. Rather than enhancing the position of nursing as a valued contributor to community health, the CAC began to view nurses as holding the project back. This is seen in the comments made by a group representing the CAC:

> "We [community members] did not kick in initially and now nursing is not ready to make decisions - they want to get input from all their colleagues. We felt three meetings ago that we were ready to be an advisory committee but this hasn't happened - the nurses have slipped gears - they tell us we [the community members] can't make a decision "wait and we will get to it"" (field notes from February 1994).

This comment reflected the frustration experienced by community members over the perceived inability of nursing to assign permanent members to the community group and to formally establish the CAC as a decision making body. At this particular time the nurses had not finalized their vision of an organizational structure (which would eventually be the CAC and NPC). As the field note cited above indicates, there was a divergence of opinion on the decision making arrangements which could or should develop.

This troubled relationship set up a difficult dynamic for the five nurses who eventually became the staff of the Centre as the following example indicates. When I visited the Centre in early May, and again in June, the staff were

engaged in extensive community networking and marketing of the Centre's possible contribution to health service in the area. As with much of the early work of implementation experienced by the nurses of the Comox Valley, the Centre nursing staff had limited ability to demonstrate this as work as understood by the CAC. This led the CAC to suggest that in order to save money, the Centre could be closed for the summer as the nurses were not busy. The CAC and the Centre's nursing staff were operating on different views of what the centre's work was to consist of and what nursing work was. The staff knew that much promotional work was needed. The CAC expected the staff to provide "nursing" in the centre.

I see this difficulty arising from the RNABC's attempt to achieve two separate goals. The two goals of demonstrating an expanded role for nursing, and demonstrating nursing's role in community development are not automatically compatible. The implications of attempting to impose the language of community development while utilizing a bureaucratic process were not recognized by the RNABC. No one therefore addressed the lack of cohesion of expectations. In the anecdote which follows I see an instance in which local nurses attempted to utilize a collaborative process and in which the pervasiveness of the

systems of work established by bureaucratic process undercuts the attempt:

> [nurse] recounted the "story of the philosophy statement", she felt that working on a mission or philosophy statement, jointly with the community committee members, would help pull the two groups together. A small group of nurses from the Centre and members of the community group worked on a short statement and finished a draft on the afternoon of the CAC evening meeting. One of the group volunteered to type out their final version so that it could be copied and distributed for discussion at the evening meeting. In [nurse's] words this became "really embarrassing" as the members of the CAC spent the initial time discussing spelling mistakes and typos made in the hastily typed draft, rather than the content itself. (field notes May 1994).

The nurse was chagrined by this. We can see it as an instance of the two groups working at cross purposes, not having developed the capacities to work constructively together. Instead of working with a group of interested residents to co-construct an understanding of community nursing practice the nurses continued to feel pressured to account for their work in ways which would gain approval of both the RNABC and the CAC.

The structure to support a new kind of practice, put in place by the RNABC, had organized and defined the relationships. The nurses had as yet no way of showing their work outside of a traditional form of reporting "up" for approval. The structure required nurses to maintain their conventional forms of action in the planning stages.

Later when the Centre opened they were required to account for their work and here too they fell back on traditional practices as they began to document their practice. This is discussed in the following chapter.

Chapter Five

Documentation - Accounting for Care

> Nursing care of the patient is not completed until the nurse has documented the care provided. (RNABC, 1992 p2)

This chapter examines the work of documenting nurses' practice. The staff nurses' stories of the Comox Valley project provided my entry into the relationship between nurses' work and the professionally sanctioned accounting of practice. Here I argue that one important constraining feature of the Comox Valley Nursing Centre is related to the RNABC's need to capture an account, textually, to demonstrate the new "unconstrained" work of nursing. I argue that the RNABC's provision of a text based system for capturing nursing is an instance of extra-local control exercised by the nurses' professional association over this project. This system of documentation organized the nurses' practice in ways which were not visible to the nurses themselves. The specific framework of the reporting system that was first used, and the normative application of professionally sanctioned document based techniques for objectifying nursing activity structured both the account and, importantly but almost invisibly, the work itself. In so doing the nurses objectified both the client and nursing,

and perpetuated the hierarchial notion of nurse as expert provider, hindering attempts to either practice or portray nursing in innovative forms. The experience of the Comox Valley nurses offers an insight into the ways in which professional practices of nursing institutionalize the ruling relations of health care delivery.

"If it's not charted it didn't happen"."[2]

Nurses have learned that recording their work is essential and that their supervisors and managers will treat seriously any oversights or errors in that aspect of their work. What motivates this attitude besides the necessary communication among members of the therapeutic team and the legal record being accomplished? Diamond (1992), in his work on the institutional care of the elderly in America, offers an explanation. He argues that the business side of "caring" organizations also operates on the basis of nurses' reporting and that it is the importance of the business of caring that makes "charting" such an important nursing function. In the business world of for-profit care, charting is a way of ensuring and demonstrating that the product that is being sold is of a certain standard. Diamond's work, based in the overtly business setting of American health care is able to explicate the relationship

[2]Diamond, (1992)

between documentation and "care" as a commodity. In the Canadian context, Campbell (1988, 1992, etc.) has written extensively on the control of nurses' work through the use of documentary practices. Campbell's work is important for my study as she identifies ways in which nurses come to understand and accept as normal work practices which originate outside local context, and which may have as goals issues which bear little relation to the local setting of care. According to Campbell (1988b) this occurs when "nurses are led to believe that compliance with such 'accountability' measures means the same thing as "professional responsibility" (p.46). Campbell's work reveals the complex process by which nursing practice is managed, monitored and controlled through its textualization. Textualization is the way in which nurses' actual work practice becomes translated into a sanctioned textual account that is part of a decision process. What is important in this process is that the form of documentation is "officially sanctioned" and is not shaped purely by the work which occurred and the experience of the individual nurse. In fact, the reverse is true. Nursing experiences must be accounted for in the categories and format of the information system. As Campbell (1988b) points out:

> When nurses translate their work into the recording system they make it objectively "accountable". The record can be compared to a written standard offering a method for establishing an accountably adequate level

of care. (p39).

In this form of accountability the record stands in for and displaces nurses' own experience of nursing action. Should anything go awry, the record will stand as the official account of the nurse's work and as such will countermand any alternate recollection which the nurse may have. Making an account thus becomes a high priority and much effort has gone into developing tools to translate nursing actions into textual versions. Key to this notion of text based accountability measures is an acceptance by nurses of the shift from decisions based on individual nursing judgment to a process by which their practice is continually measured against some form of generalized standards. Campbell points out that once patient care is textualized into objective forms it becomes subject to other interpretive processes, processes relating to managerial functions such as appropriate allocation of resources. This way of thinking allows the official record to stand in for nurses in other important administrative functions and allows centralized decisions to be made outside of the local nursing setting regarding the amount, level, and value of care which is required and provided.

Choosing an account

In the planning stage of the Comox Valley project the nurses working on the Program sub-committee made the connection between the production of a textual account of nurses' practice and the ability to evaluate the outcome of the project. As the following excerpt from the committee's report indicates, they expected the Nursing Centre staff to record their work in a way which would allow measurement of the work against pre-conceptualized outcomes. The committee had a difficult time trying to recommend a recording system that would work when they were not yet clear about what information they really needed. As they noted in their report:

> Recommendation of recording was a difficult task. Until the **purpose** of the project is clear, deciding what and how to record remains a challenge. Decisions must be made as to the **outcomes expected.** For example should the broad objectives of the Project as outlined by the RNABC be [translated into] measures? Or do we want to know how many people consulted us for help with management of heart disease. (Taken from the report submitted by the Program sub-Committee, February 1994, emphasis added.)

From the way the nurses on this committee wrote their report we see the success of the project was being linked to demonstration of nursing practice through the documentary account. Nurses related to this documentary requirement as a commonsense and routine practice. As we shall see the taken for granted nature of documentary accounting initially led the nurses working in the Centre into troubled waters.

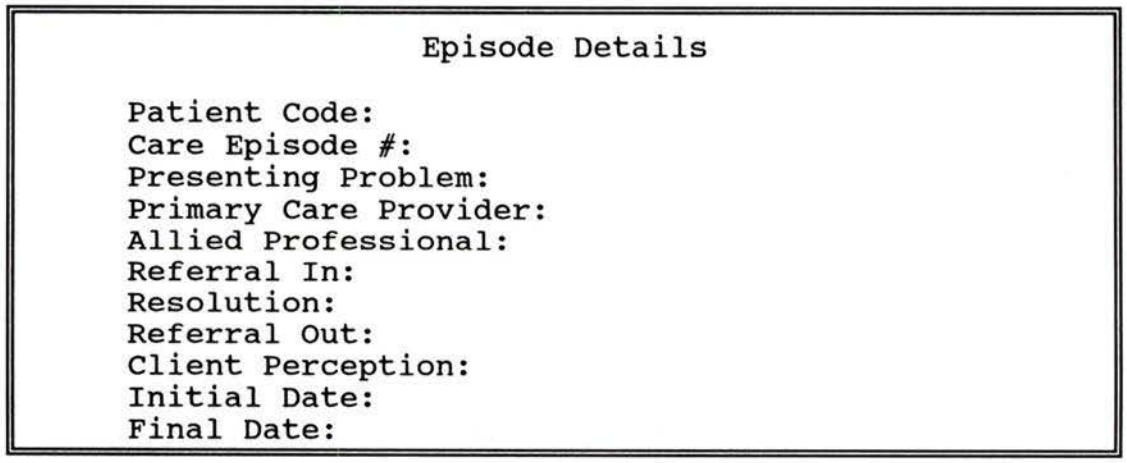
Organizing the account.

The RNABC's role in organizing the work of the Nursing Centre is seen in their early selection of the documentation system that was to be used. Local nurses recommended the use of a simple system and avoidance of the use of predetermined diagnostic sets. This advice was echoed by members of the evaluation team who also counselled using a simple system as much as possible. However these recommendations were countered by the RNABC's actions. The RNABC, also wishing to get good information chose a system that had been used elsewhere and was recommended by a member of the Association staff, and a structured documentary system was implemented. The interaction between the nurses and the RNABC as they struggled to explore the implications of a new setting for nursing is an instance of how individual attempts to practice holistically are meet unexpected barriers. In the account which follows I will show how extra-local decision making about recording by the ruling body influenced and shaped not just the kind of accounts that were made, but choices about how to nurse.

The Nursing Centre opened in Comox on May 11th 1994, with a program that was still largely unstructured. Armed with a statement of philosophy and a list of principle functions as guidelines the nursing staff opened the doors and waited to

see who their clients would be. As I have said, an early and key focus was to capture, in text form, the practice engendered by nurses' interactions with those clients. Toward this end, the RNABC had installed a personal computer in the Nursing Centre and had chosen the data base program Paradox to record statistical information relating to the work of the centre. A 'data base', as the name suggests, is intended primarily to collect and manage items of information, and to generate simple reports by aggregating data across and within categories. Information is entered into the computer program through a series of prompts which appear on the computer screen and are called, appropriately, 'screens'. See for example the screen reproduced below (Figure One).

Figure One



(Printed from Paradox screen, Comox Valley Nursing Centre May 13th 1994)

Each of the descriptors preceding a colon is, in data base

terms, a 'field', and data is both stored and can be retrieved by field. So that, for example, it would be possible to generate a list of clients referred to the Centre by a specific physician by printing the "referral in" field (line 6), or clients who presented with a specific problem (line 3). A data base program, such as the one described, appears to offer an attractive option owing to the ease with which these kinds of demographic reports can be generated.

A data base system such as Paradox, relies on the entry of data in specific codes or categories. As already noted, the nurses who worked on the Program sub-committee had difficulty in recommending what information to collect in a recording system. Committee members recognized that the goal of demonstrating an expanded nursing practice required some freedom and they made a specific recommendation on how **not** to record the work:

> Recommendation 9 - That the recording used by the nurses be simple and similar to whatever recording is already in use by community nurses. The recording should reflect the approach, and therefore nursing diagnoses should be generated by the nurse and client and not be chosen from an already created list such as Omaha[3] or NANDA[4]. (Report submitted by the Program sub-

[3]Visiting Nurse Association (VNA) of Omaha, patient problem scheme (Martin and Scheet, 1992)

committee, February 1994).

Yet we can also see that the idea of objectification into "diagnoses" is an accepted approach that takes for granted and overlooks how nurses regularly do this as part of their practice. The sub-committee nurses see the potential problem of foreign systems of categorization as an imposition. They recognized that this might constrain nurses' freedom to practice. But they are sufficiently socialized themselves to overlook that even what they see as "simple" categorization systems, such as the one described by the nurses, still accomplish the same kind of objectification and constrain the accounting of practice. As it turned out, the RNABC's choice of the Paradox system carried with it the requirement to use the Omaha or some similar classification system.

According to the staff of the Centre they had little input into the RNABC's decision about the Paradox/Omaha recording system, and no understanding of the reasons behind the particular choice of Omaha. In June, the project researchers were also unclear as to the reasoning behind the

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[4]The North American Nursing Diagnosis Association, produced "Taxonomy 1" approved by the American Nurses' Association in 1988 as the approved standardized nomenclature.

RNABC's choice.[5] In the initial stages of the project, almost two months after the Centre opened, the frustration amongst the Centre nurses was high, as the following comment indicates:

> I'll just be really honest about it - I'm kind of pissed off and you know I'm angry, that the way that it sounds like it was chosen was kind of like a flip of the coin to be perfectly honest! (Nursing Centre staff member, transcribed from meeting June 1994).

The documentation tool was much more than an irritant to the nurses. As I will show, it was a factor in shaping the way in which the nurses work, and constraining their practice as opposed to enhancing it.

For what can now be seen as good organizational reasons, from the RNABC's perspective, the Association directed the Nursing Centre staff to use the Omaha nursing categorization system. As the Program sub-committee had recognized, Omaha and other similar systems establish a predetermined set of categories for documentation of patient care. Omaha's system provides a series of **patient problems,** corresponding potential **nursing interventions**, and a set of possible **outcomes**. (See appendix A for the list supplied to the Comox Valley staff). A set numerical code is assigned to each

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[5]Subsequent discussion between members of the research team and the RNABC indicated that the Association's decision was influenced by the concepts of the Nursing Minimum Data Set (NMDS). Broadly speaking this is a movement within nursing which seeks to establish a standardized format for storing and retrieving nursing data. (CNA, 1992).

item for ease of computer entry. Theoretically a patient visit can be entered quickly and easily into the data base using discrete categories. This idea relies on the notion that a patient can be easily translated into a series of categories, a practice which objectifies the subjective human experience of the patient. As the nurses discovered, this process is discordant with an holistic view of nursing. Their experience provided an entry for me into analyzing ways in which requirements of professionally sanctioned record keeping has the potential to shape the work which is accomplished.

Objectifying the client.

In the Comox Valley Nursing Centre nurses experienced a significant disjuncture between their own attempts to work with clients in an holistic manner and the necessity to record their work using the documentation system sanctioned by the RNABC. Their overall dissatisfaction was sufficient for the research team to focus on this issue during a two day visit to the Centre in June of 1994. The following excerpt from one of the nurses' stories highlights the contrived textual re-creation of the client which the system required. The nurse says:

> It's really fascinating - the process itself - someone comes through the door and sits down. I think if we were to share that experience as far as what is actually happening with us, - we sit down and

> basically get some of the baseline information like their name and all that. But then what happens is we all have pieces of blank paper, and these conversations - some of the people that are coming in here are very multi...[problem]. You know they've been everywhere else and this is the last stop. We've got a big story. We're in for two and a half sometimes three hours with some clients. The focus is on the relationship and the conversation, and we are just writing down information on pieces of white paper. Mine's got ten pages of notes on a single client - and then what we are having to do is take those back to the documentation system because [the story] doesn't come in neat little packages right? You know what I mean! It goes all over the place and all of a sudden you can hear something that you think - oh great I need to write down that piece of information, and yes that's significant. Then we are having to go back and fit it in the boxes, right? Which is fine - I don't have a problem with that because you've got to organize the information somehow. So then we have all this information, so then we go and we take this list, this one that we've got here [a list of problem categories supplied by the OMAHA system], and we look at all our information. And we start identifying out of this list what our problems are from the ten pages of notes. (transcribed from tape of staff meeting with the evaluation team June 1994 minor editing for clarity).

This nurse is described by her colleagues as the one who "has taken a lot more time to read [the Omaha material] and make it fit for her" (field notes June 1994) and yet she clearly has difficulty fitting her client's story into "neat little packages". Later in the discussion the nurse notes:

> Plus [the chart] doesn't accurately reflect the practise you know. I mean people come in here with multifaceted issues and we're looking at it from a holistic point of view and what's being asked of us is how to chop [it up]. So the computer program is like fitting a square peg into a round hole. (transcribed from meeting June 1994).

The difficulty the nurse is describing is the process of textual mediation of reality discussed by Smith (1984,

1990).

The requirements of the officially sanctioned record shape the nurse's accounting of her work. In this example her three hours of, presumably, caring interaction are lost and the individual client is reduced to a series of objective categories and a lengthy problem list. The record of the expanded practice is being constructed but with what relation to either the nurses' actions or the clients' experience? I began to see how the requirement to document both shaped the nursing practice and distorted the account of the nurse - client interaction.

The Nursing Centre staff, as the nurse in my example demonstrated, recognized their client as a 'person' whose holistic care does not fit into a system of objective categories. They described how the system required them to selectively discount, for the record, those pieces of the client's story which were difficult to match to the available categories. In the following excerpt one of the nurses described how she dealt with the requirements of the charting system:

> As I see a client I don't have Omaha in my head thinking "Oh how am I going to fit that?" What ends up is I see the client, and I have a hell of a time afterwards when I sit down with the chart. I'm thinking "now how am I going to do this?" Because I've got all this stuff and I'm trying to cram it in to this

> thing that's called "the chart". I can't figure out where to put it all so I end up not putting everything down because its so burdensome. (transcribed from meeting with staff June 1994)

This nurse recognizes that the account she is producing is distorted. What is perhaps not recognized by the nurse is the way in which this selection for the record is work in which the nurse alone participated. The requirements of the recording system counter the interactive partnership between nurse and client. In the following pages I return to the question of partnership, what it is and how patients and nurses experience it.

Use of the Omaha system had other negative effects on the nurses' approach to their work. The nurses believed they were not consciously framing their work around the requirements of the Omaha system. I began to see that, in spite of their intentions to treat people as individuals, their recording work did influence their interactions with clients. This begins in the way in which the system directs nurses to think about their clients. The Centre nurses produced a problem oriented approach to the narrative charting which accompanied the classification system. One of the nurses described part of the charting process:

> You have to pick out all the problems from here right and you list them on your problem list the way that Omaha says and then you make sure its actual and then the problem number and then all the signs and symptoms and then the long term goal for each of them then you

> have to SOAP[6] it ... (transcribed from staff meeting June 1994).

The Omaha system recognizes (i.e. categorizes) clients in terms of clients' problems, nursing interventions initiated, and outcomes, known in Omaha as a 'disposition code'. In the following data excerpt one nurse described how this computer oriented approach led her to adopt SOAP charting in her **narrative notes - the one place where the nurses wrote about their clients unconstrained by documentary rules.** Using this excerpt, I develop a critical analysis of SOAP charting as it effects the nurse-client relationship.

> [Researcher] where did SOAP come from?
>
> [Nurse] Well I think that's what happened because the Omaha is a problem based system that was the way we could document around the individual problems that we were extracting (transcribed from tape of meeting with staff June 1994).

SOAP, is an acronym for Subjective/ Objective/ Assessment/ Plan, about which is said "this charting system [SOAP] uses a problem oriented approach. The nurse identifies patient problems and draws up a problem list, charting is done according to identified problems" (RNABC, 1992b p.3). SOAP charting, and the language it encourages, reflects what

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[6]"SOAP" (Subjective Objective Assessment Plan) charting was developed by Weed in 1964 as part of a comprehensive approach to documentation known as Problem Oriented Medical Records. Weed's underlying concept was the reliance on problem identification as a guide to medical management. In Weed's method SOAP charting, by all staff, produced progress notes which structured information in "clearly distinguishable units" (Wakefield & Yarnell Eds. 1976, p. 19).

Hiraki (1992), in a critical commentary, calls the "primacy and authority of the empirical-analytical tradition of science" (p.5). Central to this authority is an implicit reliance on objective data which, Hiraki claims, produces an imbalance in the client nurse interaction. The client's story becomes only one piece of the whole, and this piece is categorized as "subjective". As the nurse listens to the client her work is directed toward the other three pieces of the system, pieces over which **she** has principle ownership. The subjective story of the client is thus "balanced" by the nurse's objective view, and the nurse's assessment of the issues reflect her judgement. In practice, the nurses' assessment selects out those aspects of a client's story about which the nurse has "knowledge". The nurse becomes the expert adjudicator of the client's situation and her judgment has priority.

In the example following, one of the Comox Valley Nursing Centre staff presented a snapshot of a client whom she has identified as a "high risk" parent. The comments are brief and were made in the context of a discussion about assessment tools. However it appeared that the nurse had, in a brief interaction, elicited information about the client's previous history. She learned that "two of her kids are in foster homes" and weighed this information

against the current action of seeking health information. She assessed the client as on who fits a category labelled "high risk" and was thus identified as appropriate for nursing intervention. The nurse noted:

> one lady came in and she was worried about her infant who had a reaction to a drug she was taking. She wanted some reassurance and wanted to know what she should do. Should she continue the drug until the next day when she could see the doctor or not? She wanted reassurance and that's all she wanted and she wanted it quickly ... [but] I want to do an assessment on her because she is saying things about her child that I know she needs more education - lots more education - she's a high risk parent you know; two of her kids are in foster homes .... (transcribed from staff meeting June 1994)

The relationship implied in this discussion by the nurse could be seen as reflecting the RNABC's description of partnership found in the background paper for the Nursing Centre project, the Association states "through the use of nursing knowledge, people are assisted to define, analyze and act on their health concerns. (1999, p.4)

I argue however that the association's approach is an instance of a maternalistic view, which reflects the current hierarchy of decision making in the delivery of health care services. This form of thinking about clients begins from an assumption of nurse as objective expert. Purkis (1992) sees this assumption as a "naive notion of power where the nurse is taken to be merely the receptacle of physiological

and psychological knowledge aimed at facilitating healthy actions on the part of the patient" (p52). The notion that the nurse is better able to recognize a client's needs opens the door for coercive action, however gentle or well meaning, to effect a change in client behaviour. "When instrumental rationality is used to solve practical problems, power is manifested as domination and coercion" (Hiraki, 1992, p.10) The SOAP categorization approach dictates this enhancement of the nurses' power to define a situation in expert terms. This subtle intervention into nurse-client relationships operated invisibly, carried routinely within a system of documentation.

As I will discuss shortly, in the Comox Valley Nursing Centre, the nurses were able to move away from this structured form of accounting. Nevertheless, what I see as important in the present discussion is that the RNABC apparently did not recognize how some elements of nursing practice, which they support, work against the vision of nursing which they reflect in their rhetoric. As we see here, the documentation system selected by the RNABC directed the nurses' attention to the client as a person with problems to be resolved. The system draws both nurse and client into the construction of a reality which is mediated through the official record, and in which nurses

continue to act as the authority figures in the health care interaction. This recognition is important as it helps us to understand the difficulties nurses encounter while attempting to practice "alternative health delivery" (RNABC, 1993, p.10).

Nurses and community representatives in the Comox Valley project wrote a belief statement which states "we believe that nurses work in **partnership** with individuals, families, and the community to seek, maintain , and promote health." (May 1994, my emphasis). This statement reflects one of the RNABC's own explanations for choosing to develop a Nursing Centre:

> This is because nurses operationalize their partnership role through frequent exchange of information and joint decision making about health goals and the ways to achieve these goals. (RNABC, 1993, p.4)

These statements lack a fundamental understanding of the contradictions between seeing nurses as partners with the community and with their clients, and the RNABC's view of nurses as experts. Indeed, in RNABC publications and in their submission to the Royal Commission on Health Care and Costs the Association talks of nurses as experts, leaders, and resources for health who will empower their patients and their communities. The two views are not congruent; they are competing rather than coinciding.

The Nursing Centre, as organized by the RNABC reflects the value the Association places on objectivity and rationality, and on the methods of control associated with these values. This objective and rational approach to monitoring and controlling nursing practice sanctions the objectification of nurses and their clients, and makes exploration of other, alternate relationships difficult. Campbell (1994) argues that when nurses continue to provide information about their clients in ways which produce a sanctioned objective account of work for use in managing it, they are themselves engaging in the ruling practices of health care administration. Campbell argues:

> When as nurses, we want to do caring work or to help people gain more control over their own lives and health then we must first understand the **disempowering** potential of our own knowledge practices. (1994. p.37, emphasis added)

When nurses fail to recognize when, or how, they are drawn into acts which construct and support an "official view" of partnership and health care, their ability to effect change in the nursing profession is undermined.

Questioning the account

The experience of nurses working in the Comox Valley Nursing Centre has an important additional twist, one which underscores the potentially liberating effect of a less structured documentary system. Nurses recognize that when

the documentation directs attention to some, but not all, matters the client is interested in discussing, or some but not all nursing time they use they are constructing only a partial picture of the interaction. That documentary account is what stands as nurses' work. The Centre nurses were aware that the documentation system they used inadequately reflected an account of their work. The Nursing Centre demonstration project presented the nurses with an opportunity to reveal problems associated with the record keeping system. And the Evaluation Team were viewed by the nurses as a resource for identifying solutions to the problems.

During a meeting with the evaluation team all staff had the opportunity to reflect on the work of charting. The nurses identified alternate ways in which the researchers could construct nursing practice from the documentation. This is seen in the following excerpt. A staff member from the Centre says:

> Well I think it's been really helpful to talk through this. Now, am I correct in saying that we want to change this to a certain extent and possibly use a check sheet and then go narrative? I would certainly feel more comfortable with that and I think it's been really helpful to talk that through, because we keep talking about what we're missing. And part of what I think we are missing, as well, is how we, as nurses, problem solve with a client..... and I would see that the narrative would also capture that, as well as being more in line with our philosophy of being client-directed. I think we can implement that piece of

> philosophy a little easier if we are doing it in narrative way. (Notes taken at evaluation team meeting with staff June 1994)

This approach to documentation, which the nurses recognized as better fitted to the model of care they were supposed to be implementing - patient directed care - was supported by the evaluation team. I see that this support produced a mediating effect between nurses working at the Centre and the RNABC. This, in effect, gave the nurses permission to move away from the documentation system provided by the Association and into a more open narrative style of charting. Subsequently, nurses no longer had to provide a comprehensive assessment for each client in order to identify Omaha based problems. This change occurred soon after the meeting described above, and was recorded in the minutes of a subsequent staff meeting as follows "eliminate formal nursing assessment and satisfaction tool[7], do field notes narrative" (Minutes of staff meeting July 6 1994).

Over the six month period of my involvement I saw indications that the nurses' charting was undergoing a shift in focus that supported the nurses to work in ways which were directed by the client. For example, one nurse described an ongoing relationship with a young male client.

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[7]The satisfaction tool was another document initiated largely to accomplish perceived evaluation needs, the evaluation team members indicated to the nurses that it was unnecessary at this stage.

> [nurse] spoke of the frustration of not feeling she knew what she was doing but trusting her gut feeling that the relationship was the most important part and her determination that the young man would have to decide for himself what he wanted to do. (Field notes November 1994)

The nurse's story was reflected in her documentation of the relationship. The client's initial visits [in May 1994] were recorded in formal SOAP format with a list of potential problems. This was abandoned in July in favour of a journal style account. A later entry reads:

> a great deal of the visit was spent listening to J's frustration re his current lifestyle. I invited J to see if and what he thought he might like to accomplish in any further visits we might have. (Chart note from July 1994)

The success of this style of interaction can be inferred from a later note (in November) which indicated that J had dropped into the Centre to celebrate his enrolment in a drug and alcohol counselling program. I argue that the nurse was able to move into an open and supportive role with this client in part because she was freed from the necessity of accounting for an action and outcome on every visit in a prescribed form and format. Rather than focusing on the problems, the nurse could follow the client's lead and support the direction he decided to take.

The numbers game

Nursing in the late 1990's is integrally involved in discussions of health care delivery costs. A 1993 position

paper published by the Canadian Nurses Association states "nurses are ideally placed to be major players in improving the cost effectiveness of the health care system". This notion of value for health care dollars is an important component of the Comox Valley project, and is an underlying factor in what I will call the general accounting of work. References to the Centre repeatedly contain the phrase 'cost effective' health care. This aspect of the project has implications for how the work of the Centre is interpreted and evaluated. As I have indicated, these aspects are tied to how nurses report their work. Changing the recording system alleviated the Centre staff's discomfort with client work, however it did not displace the necessity of recording for external purposes. The evaluation of the Centre as suggested by the RNABC includes "examples of potential economic outcomes" (RNABC, 1993, p.9). This includes, for example, decreases in the use of the local hospital's emergency department and decreases in hospital admissions. These are indicators involving numerical evaluation. An interaction early in the Nursing Centre's operation underlines how prevalent this form of valuing work can be.

The intervention of the evaluation team enabled Centre nursing staff to address personal discomfort with the documentation of care given to individual clients. There

appeared to be no other way for people to value what nurses do other than through numerical accounting. A story given by one of the Centre staff provides an insight into the larger issues involved. The nurse related an interaction between herself and a colleague:

> And even one of the nurses at the hospital yesterday dropped in and said "so how many people are you actually seeing" and I said "well its - the drop-in is slow but there's a lot of community development work and contact with groups and agencies" And then she said "but how many people did you actually see?" and I said "well I think we did stats for last month and it was something like thirty" [and she replied] - "Thirty a day wow!" "I said no no no probably a total of thirty for the month." "Oh" - and then her face kind of fell like and I knew the next question if she was gonna say it was "so what do you do all day?" (transcribed from meeting with staff June 1994).

The concern implied by the nurse in this story is important to the outcome of this and similar projects. It is clear that the idea of staff seeing thirty patients a day was impressive, while thirty a month was disappointing. What is interesting is that the nurse's evaluation was linked explicitly to numbers. Workload measurement tools and patient classification systems, commonly used in nursing, generate what Campbell (1988) calls "officially sanctioned knowledge" expressed in terms of numbers and management-relevant categories that are commensurable. The tools Campbell examined promise to capture nursing work in quantifiable terms and, generally speaking, do so by

ascribing a numeric value to each item on a comprehensive list of care needs. Nurses then assess patients according to the number of needs for nursing care that nurses recognize. A total score for each patient is calculated and converted into a 'level of care' classification. Many tools also assign specific numbers of nursing care hours needed for each level of care and thus are used for justifying or predicting staffing on a nursing unit. This mode of thinking about nursing and nurses' work with clients is a management technology useful in making staffing decisions in large health care agencies but it is not appropriate for the management of the Centre. These workload measurement systems are based on a detailed work analysis of nursing. They may appear to provide a description of what nurses do. In actuality they have been constructed to make possible a prospective and standardized estimate of the time needed to carry out the patient care tasks as assessed by nurses. Because they are referred to, and marketed, as workload tools nurses begin to treat them as if they actually described nurses' work accurately. The usefulness of these tools is in creating, textually, an objective estimate of work that can then be used to make objective decisions regarding staffing and budgeting issues. This objective way of describing nurses' work, and their client's nursing needs is another piece of the picture in which the

subjective, contextual, stories of clients become data for categorization.[8] The Comox Valley nurses' acceptance of this way of thinking about their work was evident in a meeting of the NPC held in June 1994.

> [nurse] spoke at length - encouraging the formal gathering of detailed stats to capture the scope of practice to satisfy the CAC; there was much discussion around the use of **workload tools** and **the need to break down each item.** [nurse] has a tool she uses at work but none of the other participants had any particular ideas of how to capture the whole scope of the work. (From meeting of the NPC June 1994, bold face emphasis mine).

At the heart of the nurses' struggle is their need to account for the work in ways which will be understood, and, by extension, valued. In the discussion of workload and statistics the nurses are again pulled into an accounting of practice which seeks to describe care in objective ways. The caring, collaborative, interactive work which was liberated in the nurses' notes again becomes invisible. This work, which is valued by the recipients, does not translate into an easily accountable form which can be recognised by those not engaged in the work. I see this dilemma expressed in the concern over the perceived low

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[8]The RNABC has no official position on the use of any specific patient classification tools, however their acceptance of the underlying principles is seen in their use of such systems as Omaha,and their support for the technological management systems of the NMDS. Additionally, in the submission to the Royal Commission the RNABC called for "aggressive support for further development, implementation and evaluation of nursing workload systems" (RNABC, p.40)

number of visits and the investigation of workload tools. This concern by the nurses to account for their time also relates to the suggestion made by the CAC that staff should take the summer off (unpaid) as they were not busy - thus saving the Centre's budget. (field notes June 1994) Their productivity **is** being scrutinized. They must make an objective accounting.

I see in this concern an example of the findings discussed by Ng (1988). Ng examined the workings of a community based organization for immigrant women. Ng's work demonstrated that the requirement to account for funds in ways valued by the funding body directed the agency staff's attention to a definition of success which had little relation to the initial aim of the project. While the long term evaluation of the Nursing Centre project will include an extensive exploration of clients' responses, both in terms of outcome and satisfaction, the nurses' attention becomes focused on numbers. As I have shown this had an effect making the immediate day-to-day accountability for the nurses' work less clearly client-directed. Rather the nurses were concerned to account for their work to the CAC, the NPC and the RNABC.

I argue that the requirement the nurses feel to account for

their practice, and by extension their time, directs the nurses to seek ways of working which can meet the expectations of their overseers. The following story about programs demonstrates one way in which the nurses addressed this pressure.

Over the course of the first six months the nurses began reporting activities in terms of programs and quickly established a list of 20 such activities, including for example: Geriatric Assessment Program; Chronic pain; Citizen Advocacy; (See Appendix B for complete list). In contrast to their extensive documentation of direct care, these activities were recorded by means of small folders for each of the programs with notes of meeting dates, agenda's, and lists of potential contacts or resources (field notes November 1994). Such group activities were less susceptible to the kind of implied cost/benefit analysis that might be applied to the nurses' reports of 'visits' certainly to the level of analysis available to the local Committees.

In November 1994 when I visited the Centre I noted how extremely busy the nurses were, and that they were engaged primarily in group activities. It is my contention that the nurses' organization and subsequent documentation of their work as programs responds, at least in part to the need to

account, rather than to the need of purely client-driven care. During the period under discussion, the nurses established a more formal appointment system for client visits and limited the time of each appointment. In other words they moved from an open and unstructured format dependent on user initiative to a model which more closely replicates the standard model of health service delivery in which access is controlled by the provider. Once again nurse-client interaction is being shaped by relevancies that arise in the need to account rather than in client needs. This adds to the growing body of evidence that suggests that nurses' practice is constrained by issues, structures, models of control that are organizational, not just by 'medical dominance'.

In this chapter I have argued that the ways in which nurses account for their work is one way in which they are organized into the health care hierarchy. The requirement to account, in a professionally sanctioned form, limits the way in which the nurses can practice. Professional accounting is one form of managerialism that creeps into nurses' practice and shifts their attention away from responding to clients needs. I have shown that at the heart of the recording systems imposed on the Nursing Centre was a concern about the production values of the health care

system. It is unfortunate that this pragmatic value also constricts the way that nurses can renew their professional practice.

In the next chapter I will examine the relationship between nurses and physicians as health care providers from the standpoint of the Comox Valley nurses.

Chapter Six

Constructing a hierarchy

In the preceding two chapters I showed how nurses, in their everyday work, play an integral part in the network of social relations which make up the health care system of British Columbia. Offered places to expand their practice, nurses have continued to find their work constrained. I contend, therefore, that the traditional organization of health care is entrenched by more than the "restrictive regulations" described by Rachlis and Kushner (1994). I have provided evidence of how the constraints on nurses are organized within nursing as part of the routine manner in which nursing is regulated and managed. Nurses are active participants in the organization of their practice. They are not passive victim but are involved in maintaining their subordination. In this chapter I analyze some data that further illuminates how this works. I draw on data from the Comox Valley Nursing Centre to analyze how nurses determine 'nursing work' in relation to 'physician work'.

Nurses work from a subordinate position and they continue to organize their work in ways which perpetuate the existing patterns of the health care hierarchy. Moreover, I argue that the RNABC's reluctance to address this relationship, as evidenced in the Comox project, models for nurses a

continuation of the subordinate approach to powerful others.

Physicians as colleagues? - the RNABC approach

The RNABC describes the nurse-physician relationship in positive terms, in their submission to the Royal Commission on Health Care and Costs stating:

> For the most part nurses and physicians practice as colleagues on the health care team. Obviously many of the duties that nurses perform, administering medications for example, are generated by physicians. (1990b, p.17)

This account of how nurses and physicians work together lacks the specificity that would inform readers about the problems nurses experience in the relationship. It actually misinforms, if we accept Rachlis and Kushner's (1994) account:

> This ideal of team-based practice in a mutually respectful state of interdependence doesn't mesh well with the fact that doctors are trained in virtual isolation from other health professionals. Reports on primary health care talk about "collaborative" practice models and a flattened hierarchy in which doctors and nurses each function to their full ability. But most family practice training programs continue to represent nurses as handmaidens - a completely outdated and resented role. (p.180).

Additionally, Rachlis and Kushner point out that physicians have typically not welcomed challenges to their domain. This contention is supported by the response of physicians to the Nurse Practitioner movement in Ontario in the 1970s (Manga, 1992). The RNABC proposal for a pilot project

utilizing a Nursing Centre was greeted with just this style of opposition. The response from Dr. Keith Phillips, president of the British Columbia Medical Association's society of GPs is quoted in the 1993 fall newsletter of the Nurse Practitioners' Association of Ontario:

> [Dr Philips] claims the introduction of nurse-practitioners is a feminist-driven plea which will increase referrals, save no money, and runs counter to the GP's drive for more generalism. ... Dr. Phillips is concerned that the clinic [the proposed Nursing Centre demonstration project] will be in direct competition with GPs.

Dr Philips explicitly challenges the cost-efficiency claim of the RNABC proposal, saying "[the Centre] will cost more money" and he pinpoints as the site of contention that "[nursing practice] will be in direct competition with GPs". This reaction to the mere announcement of the beginning of the project is an indication of the importance of addressing the relationship between these two groups.

I return to my earlier contention that the RNABC attempted to neutralize physician concerns about the demonstration project by avoiding a direct challenge to medical practice. That is the tone of the background paper for the Nursing Centre project that states only that:

> This project will also help nurses gain a better understanding of different ways of working with the public **and other providers** in an evolving health care system (1993, p.10, emphasis added).

In addition, the RNABC explicitly chose to avoid the

contentious Nurse Practitioner model. At an RNABC chapter meeting in Victoria in June of 1994, Heather Mass stated that the Association had deliberately chosen not to implement the Nurse Practitioner model as the Association believed there was already a significant body of literature which addressed this form of nursing practice (RNABC meeting, Victoria chapter June 1994). Mass talked more generally about an expanded role for nurses, a position which fits more easily with the Ministry of Health view as discussed by Henning and Cox (1995). However it is clear from Dr. Philip's comments that physician's recognized the competitive possibilities inherent in nurses' expanded roles.

The 'nurse-only' planning phase which excluded the community members also excluded physicians from the early phases of the project. There was thus no opportunity for the two principal health care professions to engage in discussion, or to establish from the outset any better understanding of nurses' work. In the absence of any specific plan to work in a collaborative way during the implementation phase, local nurses working on the project shelved the question of physician participation. As one nurse told the evaluation team in February:

> The public relations committee didn't really get going until recently because they didn't know what the centre

> would be doing - they didn't know what exactly to promote to the physicians. (Field notes February 1994).

The nurses apparently accepted that a straightforward communication from one professional group to another would not be sufficient, and they implicitly accepted the need to promote - or persuade - physicians to accept the Nursing Centre as a player in the health care services of the Comox Valley. Given the nurse-only approach to planning it is reasonable to assume that professional courtesy would require communication with other health care providers; and it is reasonable to assume that the nurses would expect, and want, to describe their new service in a positive and attractive manner. What is of note here, however, is the emphasis placed by the nurses on communications with local physicians, rather than to **all** other health care providers. I argue that this emphasis on physicians, even in this nurse-only setting is an instance of nurses' understanding of medicine, i.e. physicians, as the dominant players in health care. Gregor (in press), speaking of Canadian nurses, contends that medical dominance "is a taken for granted feature of work organization wherever health care work is done" (p.8).

The RNABC's carefully chosen approach masked the underlying challenge to physicians, creating problems for local nurses. The following data excerpt from a meeting with Comox Valley

physicians in February 1994 outlines some concerns expressed by the local physicians. One physician notes:

> "There is a high degree of paranoia from Family Practitioners because of the perception the nurses are setting up a Nurse Practitioner practice which would take over family practice - the meeting with [nurse from the planning group] last week was good, but too little too late" (from Grand Rounds meeting with the evaluation team February 1994).

This lack of trust continued and, as was discussed earlier, led to the lack of working relationships with physicians which is reflected in the following note:

> [nurse] talked about the relationship with the community physicians which she sees as "non-existent". The local family practitioners supposedly had a liaison physician (to the Nursing Centre) but according to [nurse] she "never sees him". She said she has taken the initiative on several occasions but even then he doesn't pass on any information to his colleagues - he told her "I can't take that on". [Nurse] links the low numbers of drop-in clients and individual clients in general to the lack of physician support. "We could do more if we got more referrals from the docs". (Field notes November 1994).

There was of course no intrinsic benefit for the physicians to enter into this partnership, and in the physician's eyes a good deal to lose. It is likely that the physicians had no existing practice of collaborating amongst themselves, let alone with outsiders. They had already stated their concern that nursing would infringe on their work, this concern being possibly linked to their concerns about maintaining the existing levels of their financial compensation.

Who owns the patient?

What needs to be recognized is that relocation of nursing to a neutral site of practice does not replace the existing relations of the health care system in which nursing practice is shaped and constrained. Even in the community there are mechanisms, largely controlled by physicians, that determine how health care is practised. Physicians, indeed, expect to control all aspects of 'their' patients' care. Numerous references in the literature lend credence to the pervasiveness of this view. For example a paper on the role of nurses (written by physicians) in the New England Journal of Medicine (Stein et al, 1990) prompted an acrimonious exchange of letters. The salient point of agreement was that the patient was the **physician's** responsibility. The notion of patient ownership was raised by the physicians in Comox. In a meeting in February 1994 the physicians constantly referred to "my patients" - " how will I know what is happening to **my** patients".

In British Columbia, access to almost all forms of publicly funded health care is controlled by physicians, and for all realistic purposes the patient is 'owned' by physicians. This ownership is manifest in the numerous ways in which people interact with the health care system. The legitimacy of the physician's control is for the most part

unchallenged. This notion of ownership of the patient is important as it exemplifies the power relations I seek to explicate. Nursing has struggled to develop a practice which is independent of physicians. Not only do nurses feel professionally demeaned by their subordinate position, but even as new approaches to health care challenge the medical model, nurses find themselves tied to the medical curative model under the control of physicians. I have already discussed ways in which health care service evolved historically and it is clear that the ownership the physicians feel is both operationalized and reinforced by health care legislation, insurance, hospitals and so on.

Control begins with the physicians ability to designate 'patient status'. In a study of the evolution of labour division in nursing Gamarnikov (1978) notes:

> Medical dominance in health care manifests itself by limiting the access to patients of practitioners in other health occupations by means of monopolising the initial intervention which designates the patient qua patient (p.106)

It is exactly this designating feature of medicine which wellness-care, and primary health care as promoted by nursing, seeks to challenge. However, as the nurses at the Comox Nursing Centre discovered, the structure of the health care system functions to control and limit the ways in which nurses in the Comox Valley Nursing Centre could work with

clients.

For example several women approached the centre with questions regarding menopause. Previously regarded as a normal stage in a woman's life cycle, the advent of hormone therapy has precipitated this period into the realm of medicine. Nurses at the Centre were able to provide the women with a range of information, however if a woman's choice of menopause management did not then coincide with her physician's the nurses found they had little ability to assist her. In one example described to me, the nurses were concerned with the quality of advice given to an elderly client diagnosed with osteoporosis. The nurse felt the client would benefit from an assessment at the osteoporosis clinic in Vancouver, however at the time of my involvement they had not been able to achieve this. Access to the Vancouver clinic is controlled by physician referral. This client's physician was resistant to this idea.

In theory the client has the option to change physicians and select one more open to discussion and collaboration. This process ignores the personal power vested in physicians by the general public and the social difficulty involved in changing physicians, particularly in small communities. According to members of the evaluation team, the Nursing

Centre staff have acted as advocates for several of their clients in this regard assisting them in finding a physician more suited to their personal needs. This mediating role which the nurses have accepted is helpful to clients - but who still 'owns' the patient? Doctors, even when nurses try to work on behalf of clients their options are limited and they do not feel they have the right to challenge this ownership directly.

Co-construction: nurses and the health care hierarchy

In the example above I discussed some barriers physicians created for nurses trying to work in the community. Recognition of these barriers is an important component of addressing changes in the health care system. However these barriers are, in some sense, visible. I will now turn to an equally pervasive but less visible factor which also shapes nurses' work. The Nursing Centre seemed to offer a place which would allow nurses to concentrate on aspects of care that are unique to nursing, to step outside the notions of ownership and medical practice. Nurses, however had to interpret and operationalize this freedom. My research indicates that the freedom implied by the setting was offset by the ways in which nurses had learned to work. Earlier I discussed how nurses learn to view and account for their work in textual form. Here I consider some accounts of

nurses' interactions with clients, offering insight into how nurses differentiate their practice from that of physicians.

The first example occurred as a telephone conversation and is described in my field notes:

> While I was talking to [nurse] the receptionist put through a telephone query. The client had been stung by a bee two days ago and wanted some advice about the persistent swelling. L. gave some very general information and advised the client to call her physician "if you are worried". Afterwards [nurse] told me she felt very uncomfortable giving medical advice over the telephone - but at the same time she worried about referring the client to her physician "people will wonder what good we are" (Field notes May 1994)

I was witness to the staff member's side of the conversation only, which was brief, but it was clear in our subsequent discussion that she was competent to respond to this client's concerns. In an informal interaction - with a family member or friend for example - she would have done so without recourse to a physician. Nevertheless in this professional context, the nurse categorized the client's concern as medical and therefore outside her domain.

A second example provides another view of the nurse client interaction. I also witnessed this event. The anecdote is described in my notes:

> A "drop-in" client came into the centre just after lunch and asked for some information about antidepressant drugs. She told one of the staff that her adult son, living in Toronto, had recently seen a

> psychologist who had recommended a course of anti-depressants. While the staff member searched for some information she engaged the woman in conversation through some open ended questions "you're feeling a long way away from him?" and "even when they grow up you still feel responsible ...". These led to a lengthy session with the client and two staff sitting in the Centre's open area talking about the woman's concerns and worries. No specific advice was offered. The client "told her story" and her concern was acknowledged. At the conclusion of about thirty minutes she stated that she felt much better and left with a photo copy of some drug information. No attempt was made to review or discuss the literature. (Field notes May 1994).

These two stories show an interesting dichotomy, and provide a beginning place to explore how nurses construct their practice in relation to physicians. In the first example, the nurse had no hesitation in identifying the concern as 'medical'. She subsequently identified some discomfort in having directed the client to a physician, however the possibility of responding as a nurse, and providing a definitive consultation herself, was not seen as an option. In contrast, the second client's drug query posed a potentially more complex medical question - the pharmaceutical action of anti-depressant therapy. In this interaction the nurses handled the situation themselves with no discomfort as in the first instance, and seemed to feel no need to refer this client to a physician. The second client's response to the nurses' approach which recognized her feelings apparently identified for the nurses that this was a "counselling" or "supportive" interaction and thus fit

comfortably within their domain.

According to the RNABC, the nurses can be considered to be applying "specialized knowledge and skill of the nursing process" (RNABC, 1990) to this interaction. This may well be the case, certainly in my view they applied intuition and empathy. I want however to analyze this interaction further. The advent of curative medicine placed prestige on the technical aspects of care and these have long-since been appropriated by physicians. Financial incentives in the health care system are closely allied to this aspect. Physicians are "well rewarded for seeing relatively healthy patients with minor illnesses" (Rachlis and Kushner, 1994). Conversely, with few exceptions, they have limited ability to bill the system for lengthy consultations. Physicians have thus become content, for the most part, to allow nurses to take on the role of educator and supporter. A discussion by Savage and Witz (1992) on the work of Dorothy Smith is helpful here. Referring to Smith's conception of women as "where the work is done" the authors go on to state "[women] are facilitating, cleaning, tidying, bolstering, soothing, smoothing over, sustaining etc.." (p.25).

Savage and Witz are referring to the role of women in offices and business, however I contend that their concept

applies equally well to nursing - nurses 'tidy up the mess', they counsel, support, facilitate, and coordinate, etc., and allow physicians to move on to the next important act. Patients, of course, appreciate the work that nurses do in this context. But, as Gregor (in press), discovered even this work is not always presented as nursing work. In a study of surgical nurses she found that nurses did not utilize their nursing based knowledge of the recovery process in their educative work. Instead, nurses consistently tailored their patient teaching to reflect the known preferences of the surgeon involved. Additionally, the nurses consistently shaped their discussions with patients around the actions of the physician. I see a similar dilemma for the nurses in the Comox Centre. This is professional subordination at the level of nursing practice. A new place of work does not automatically lift this subordination.

I see elements of this subordination in the discussion which occurred between members of the Chronic Pain group run by the staff of the Nursing Centre. This group had been initiated by the nurses in response to interest expressed by a number of clients. I was present at one of their meetings. What follows is taken from the notes I made at the time.

> The group are very interested in a therapeutic touch workshop and plan to organize and sponsor a daylong session to learn how to use this technique. Some discussion on how to identify the potential audience. Much discussion on how to "bring physicians into the loop" - One of the nurses had some information on a new pain service but it required fee for service funding (I.C.B.C/W.B.C. etc) and was therefore dependent on physician referral. (November 1994).

This anecdote underscores the implicit expectation, by both patients and nurses, that physician approval must be sought. It also demonstrates that, as in so many instances, the structure of health care delivery serves to institutionalize medical primacy.

Based on the findings of my analysis in this chapter, it appears that if nurses indeed desire to work in a more autonomous way the profession will have to address the inequities that remain a problem for nurses in the health care system in a more straight forward manner.
As a beginning point nurses and their professional organizations must recognize how inequities occur through power which is expressed relationally everyday between physicians and nurses. Taken for granted assumptions regarding those very relationships continue to contribute to nurses' subordinate position within health care.

Even in this innovative project, the language of the proposal and various choices made by the RNABC modelled a

conciliatory approach that left the dominance of the medical profession over nursing practice unchallenged. It would be unreasonable to assume that the Nursing Centre staff, working as individuals, would be able to solve systematically organized problems that appear in their everyday working relations.

Chapter Seven

Conclusion

At the beginning of my paper I used the metaphor of a journey. I described nursing as charting a course and exploring new directions. As I worked through this paper I came to understand that in many ways the biggest challenge for nurses is to recognize and chart, not new directions, but old and hidden barriers. My study considered a small part of nursing work and I sought to illuminate some of the ways in which nurses work is constrained. In my conclusion I want to discuss, if only briefly, some questions which arise from my work.

My goal in this thesis was not to evaluate the work of the Centre, nor the extensive work of the nurses involved. My intent in this project is to provide an analytic contribution. The nurses work in the Comox Valley directed me to reflect on the work of nursing in British Columbia and I provide an analysis which illuminates some of the difficulties nurses face. The Comox Valley Nursing Centre was in many ways a risky undertaking. Nurses in the Comox area, and the staff of the Centre allowed their work to come under intense scrutiny. This scrutiny did not only involve the official Evaluation Team, nurses across the province eagerly awaited reports and asked for information.

In one of my visits to Comox I asked a member of the Centre staff how she would describer her work. "Essential" she replied. During my study I came to see that for the period I observed the nurses were doing exemplary work in a field in which they excel, that is coordination of care. My concern is that acceptance of this work will mask questions which should be asked. An anecdote from my data illustrates my point, and is discussed below.

As I noted earlier, clients coming to the centre tended to have many concerns. In the words of one nurse they "are falling through the cracks". The story of one of these clients was given to me by a member of the Centre staff:

> [nurse] told me about one of her clients, a woman who has presented at the local emergency department with suicidal ideation on a number of occasions. [The nurse's] frustration is with the mental health service, apparently this client has been seen on an emergency basis and referred for counselling - for which there is a three month wait. This has happened before and, previously, by the time the appointment was due the 'crisis' was over and the client cancelled the appointment (apparently much to the annoyance of the local mental health office). [Nurse] sees her role this time in advocating for mental health services for the woman and attempting to 'keep connected' with her until the appointment comes through. (field notes, November 1994).

For this client the nurse is meeting a very real need and her intervention may be literally life saving. However it masks the question of adequacy of mental health resources in the community. Is there a gap in service or is there a lack

of resources for an already identified need? In other words does this client need nursing care or does she need mental health services available to her in a more timely manner?

There is no question that the services provided in the Comox Valley Nursing Centre are valued positively by the recipients. There is also no question that these services do in some sense improve the health of those served. This has been well documented by members of the Evaluation Team. However I argue that the gaps in service filled by the nurses are thus masked, and that nurses continue to co-create the inefficiencies and inequities of the health care system.

The RNABC has tied its professional stance to the concepts of primary health care as a cost effective model for health care delivery. My concern is that nurses, through the agency of the RNABC, will be drawn into supporting government initiatives which compromise the public advocacy position the profession purports to be taking. I argue that in order to deliver on its cost effective promise, the nursing profession needs significant structural changes in methods of health care delivery. It is, at best, counterproductive to assume otherwise.

The subordination of nursing permeates the organization of health care, played out in time honoured and traditional approaches which continue unchallenged. Unless we engage in critical reflection these approaches will continue unchallenged and will continue to stifle the possibility of creative change. I have argued for a critical reflection from a feminist stance. This means we must take what nurses do and say seriously. When we return to the practice of nursing and account for how it comes to be, the relations which structure the work will be revealed. Deconstructing practice in this way is not destructive, rather it helps nurses to see how nursing is embedded in practice which works against the new ideas of partnership and collaboration the profession seeks to promote. The kind of understanding I promote assists nurses to engage in discussions about collaboration and partnership from a much more realistic and effective position.

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Appendix A

Omaha Codes for the Comox Valley Nursing Centre

Modifier

1. Health Promotion
2. Potential
3. Actual

Problem

Environmental

1. Income
2. Sanitation
3. Residence
4. Neighbourhood/workplace safety

Psychosocial

5. Communication with community resources
6. Social contact
7. Role change
8. Interpersonal relationships
9. Spiritual distress
10. Grief
11. Emotional stability
12. Human sexuality
13. Caretaking/parenting
14. Neglected child/adult
15. Abused child/adult
16. Growth and development

Physiological

17. Hearing
18. Vision
19. Speech and language
20. Dentition
21. Cognition
22. Pain
23. Consciousness
24. Integument
25. Neuro-musculo-skeletal function
26. Respiration
27. Circulation
28. Digestion/hydration
29. Bowel function
30. Genito-urinary function
31. Antepartum/postpartum

Health related behaviours

32. Nutrition
33. Sleep and rest patterns
34. Physical activity
35. Personal hygiene
36. Substance use
37. Family planning
38. Health care supervision
39. Prescribed medication regime

40. Technical procedure

41. Other

Intervention categories

1. Education

2. Health skills counselling

3. Health care intervention

4. Follow-up/referral

5. Community collaboration

Intervention targets

1. Anatomy/physiology

2. Behaviour modification

3. Bladder care

4. Bonding

5. Bowel care

6. Bronchial hygiene

7. Cardiac care

8. Caretaking/parenting skills

9. Cast care

10. Communication

11. Coping skills

12. Day care/respite

13. Discipline

14. Dressing change/wound care

15. Durable medical equipment

16. Education

17 Employment

18. Environment

19. Exercises

20. Family planning

21. Feeding procedures

22. Finances

23. Food

24. Gait training

25. Growth/development

26. Homemaking

27. Housing

28. Interaction

29. Lab findings

30. Legal system

31. Medical/dental care

32. Medication action

33. Medication administration

34. Medication set-up

35. Mobility/transfers

36. Nursing care, other

37. Nutrition

38. Nutritionist

39. Ostomy care

40. Other community resources

41. Personal care

42. Positioning
43. Rehabilitation
44. Relaxation/breathing tech.
45. Rest/sleep
46. Safety
47. Screening
48. Sickness/injury care
49. Signs/symptoms, mental emotional
50. Signs/symptoms, physical
51. Skin care
52. Social work/counselling
53. Specimen collection
54. Spiritual care
55. Stimulation/nurturance
56. Stress management
57. Substance use
58. Supplies
59. Support group
60. Support group [sic]
61. Transportation
62. Wellness
63. Other

Disposition codes

A. No further assistance by Nursing Centre required.

B. Discharged to care of physician.

C. Discharged to care of hospital.

D. Discharged to care of Continuing Care.

E. Discharged to care of Public Health.

F. Discharged to care of long term care facility.

G. Discharged to care of:

H. Moved out of area.

I. No further contact by client.

J. Deceased.

Appendix B

Comox Valley Nursing Centre Project List

(October 1994)

1. Geriatric assessment program
2. Partners in Assisted Learning (PAL)
3. Chronic pain
4. Special sitters
5. Transition house
6. Teen projects
7. Adult literacy
8. Multi-cultural society liaison
9. Education program for eating disorder prevention
10. Drug and alcohol awareness week
11. Health sessions - Comox community centre
12. Seniors wellness outreach
13. Heart health
14. Food bank
15. Coordinator of support groups
16. Community health workers project
17. Stress management
18. Citizen's advocacy
19. Community outreach
20. Support group for individuals who have given or are considering giving up a child for adoption.

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