

In the Name of Cancer Nursing: Organizational Change and Oncology Practices

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Abstract

This dissertation studies a process of change as evidenced in the everyday conduct of cancer nursing within the context of the ambulatory care setting. The purpose of this study was to explicate relationships of leaders of nursing practice, practitioners, and patients and families, and how these relationships serve to shape, in particular ways, the outcome of planned organizational change. The study enabled a questioning of how leaders, widely thought to be 'responsible' for marshaling change processes through organizations, would know that practice, had, in fact, been positively changed or improved as a result of the change. Further, the study undertook to question whether and how leadership practices operate to resist consensus and foster the inclusion of conflicting knowledges arising out of differences in position, and knowledge of practitioners, patients and families, and managers.

In order to contextualize and keep central the concept of practice in the study, I have drawn on the work of Michel Foucault. Foucault's conceptualization of practice links action with language in ways that require a careful analysis of how action changes when discourses, such as 'specialty practice' or 'organizational change' are introduced as part of a program associated with changing how nurses undertake their work. Following Foucault's claim that our knowledge is manufactured and produced by our discourses and practices, the focus of the analysis was to reveal the knowledges that the nurses draw upon to explicate and conduct their practice.

A detailed examination of the organizational change initiative documentation and interviews revealed contradictory aims in the proposed changes to the patient care team. Nurses were seemingly unaware of these competing aims. Nurses explicated their practice differently at each of the clinics revealing how 'membership' and 'belonging' mediate the discourses that they draw upon to 'talk' about their practice. Analysis of observational materials revealed remarkably similar practices in each of the clinics. This finding points out how powerful organizational structures, such as schedules, routines, assignments, and policies affect the enactment of practice.

Nurses described their practice using the language and discourses of 'expert' and 'specialist'. Analysis did not reveal a discernible model of care, but did suggest that nurses predominantly draw upon their disease related knowledge when caring for cancer patients and families. The 'local' knowledge of 'how things get done' in the everyday is not acknowledged. I suggest that relying on 'expert' knowledge, 'disciplines' the behavior of patients and families.

What emerges from this study is that nurse leaders are one of the powerful influences that affect how practices are accounted for. The incongruence between nurses' accounts and leaders' accounts is not merely about differences in hierarchical position. Nurse leaders' accounts rely upon proxies such as timeliness, workload

measures, patient and physician feedback, and are framed against a technical, managerial perspective of practice. Revealing these differing practice interpretations provides nurses and leaders a way of understanding how successful changes to practice must be planned in a way that takes up the knowledge of not only the leaders but also the nurses.

Lastly, the knowledge of patients and families was not immediately apparent in the organizational documentation or the observations. Individualization of care competes with organizational standardization. In a time of continuous changes in health care, the perspectives of patients should not be relegated to the background, but must take their rightful place in the foreground with other health care providers.

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Chapter One: Introduction

Thinking is difficult when words are not our own. Borrowed concepts are like passed-down clothes; they fit badly and do not give confidence; we lumber awkwardly about in them or scuttle off shamefacedly into obscurity (Gardner, 1996, p. 153).

Study Context

Health care restructuring – practice implications

As a nurse leader working in the health care system, I have often participated in changes that are purported to benefit patients in the name of restructuring. I have become dissatisfied with the apparent lack of patient benefit that has resulted in these types of changes, and the impact that these changes have had on nursing practice. Well-meaning leaders, including nurse leaders, who are also trying to catch up with ever-changing organisational goals, often initiate changes to practice. I am concerned with the plethora of changes that health care organizations continue to undergo and how I, as a nurse leader, participate in these. Often, even when changes are 'imposed', there are opportunities to influence the choice of changes, and also which changes to resist. I am interested in how I might ascertain what types of changes might have positive outcomes.

Health care organisations in Canada share many of the features of large organisations in both the private and public sector. The bureaucratic and hierarchical nature of these organisations creates ideal conditions for structural inequalities to prevail. The management of health care is influenced by dominant organisational discourses focusing on the business and economics of providing care. Nurses are often caught between organisational imperatives and nursing practice goals. Their struggle to be efficient is impeded by their desire to practice in a manner consistent with their

professional knowledge and standards. Somehow nurses play out these competing interests in their everyday clinical practice. Like me, they seem to have some space to manoeuvre within. I am interested in exploring the characteristics of these spaces, as the tension between organizational goals and practice goals has contributed to a growing dissatisfaction amongst nurses in Canada.

A recent publication of the Canadian Nursing Advisory Committee (CNAC) (Health Canada, 2002) states, “there is an urgent need to repair the damage done to nursing through a decade of healthcare reform and restructuring ” (p. i). The report goes on to make fifty-one recommendations designed to “improve the quality of nursing work life at the federal, provincial and territorial levels” (p. 1). Included are recommendations related to workload, overtime, absenteeism, work environments, policy development, and so on. Each of the recommendations requires some type of action on the part of governments, ministries, and organisations. Many of these actions will necessitate changes in the nurses’ work environment, which I argue will impact nurses’ practice. As a nurse leader, I am worried that these recommendations, similar to many of the restructuring initiatives of the past, will result in another set of changes that may appear correctly responsive to the report – but may not positively impact nursing practices or benefit patients. I suggest that changes are often based upon assumptions about nursing practice that fail to take full account of the meanings everyday actions hold for nurses. Before undertaking yet more changes, I believe it is necessary to try and understand how previous restructuring changes have been taken up, the impact that these have had on nursing practice, and from there, to propose understandings of nursing practice that

acknowledge multiple perspectives held by practising nurses. All of whom would claim a consensual identity of “oncology nurse.”

Re-structuring oncology nursing practice

Nurses in oncology practice in Canada have not been immune to the effects of restructuring efforts (Ashley & Cross-Skinner, 1992; Porter, 1995a; Porter, 1995b). This study takes place in a cancer organization in Western Canada that underwent a major re-structuring, re-engineering process in 1996 with implementation of changes in 1997/98. The purpose of the re-structuring was to “develop alternative methods of organizing and leading health care delivery systems” (Cancer Agency, 1995, p. 8).¹ The assumptions underlying the management changes and the resulting changes to nursing practice provide the backdrop for this study. As this study took place approximately three years post-restructuring, it provides a powerful case study of how organizational changes designed to influence patient care actually affect nursing practices.

In this study I am interested in exploring oncology nursing practice and the relationship between these everyday practices and the organisational change initiative. I am further concerned with identifying and explicating influences that impact how practice changes are enacted in the presence of an organizational change initiative.

This ethnographic study conducted at two cancer clinics in Western Canada, explores how nurses have created and continue to create spaces for practice within a dominant patriarchal health care system that underwent a major organisational restructuring change approximately three years pre-study. I am interested in identifying the knowledge that these nurses draw upon in their self-identified expert and speciality

¹ References to the organization are fictitious to protect confidentiality.

practice, by studying what is included and excluded, absent and present, and mediated through the discourse of oncology practice. Following Garfinkel (1967), speciality practice is seen as an elaborate social accomplishment.

Nurse leaders

Nurse leaders are called upon to participate and, indeed, often do lead, organisational changes that affect nursing practice and patient care, (Borthwick & Galbally, 2001; Gelinas & Manthey, 1997; Gilmartin, 1996). In my role as a nurse leader in oncology I am expected to “provide leadership in the development of role concepts, delineating scope and level of practices for nursing working within the overall cancer control system” (Cancer Agency, 2000, p. 2). As such I will be called upon to respond to the CNAC Report and develop a plan to make changes that will result in the improvement to the quality of nurses’ work-life. I am uncertain how I would know how and what types of changes to the nurse’s role or practice might positively affect patients while at the same time enhancing professional growth. Therefore, I am interested in the impacts that the previous organizational restructuring and leadership decisions have had on everyday practice, so that I might develop a deeper understanding of oncology practice upon which my future decisions might be made.

Typically, changes are made in organizations without an understanding of how past changes have affected practice. If outcomes do not take place as anticipated then another series of changes are undertaken. The CNAC Report (2002) indicates that many of the “solutions” or changes of the past decade have contributed to the problems of today. For example, in the name of containing costs and increasing efficiencies, nurses were laid off in the 1990s and unregulated workers were hired to look after some of the

care needs of patients. The CNAC report cites a study by Aiken, Sloane and Sochalski (1998) that suggests “ a higher proportion of hours of care per day provided by RN’s was associated with shorter lengths of stay, lower rates of urinary tract infections and upper gastrointestinal bleeding, lower rates of pneumonia, an so on” (p. 224). According to this study and many others, downsizing and changes to ratios of nurses to patients in the name of cost and efficiency has resulted in the opposite. Higher patient complications translate into higher costs.

In the changes that occurred in the organisation under study, nurse leaders were key participants in the development of practice changes. The views of nurse leaders post-change are examined in relation to the perspectives of the staff nurses. Similarities and differences are explicated as it is critical for nurse leaders to understand how nursing practice maintains recognizable forms, perhaps in spite of managers’ intentions to change it, and yet at the same time, is enacted by individual nurses with individual patients as unique and different beings in the complex context of care.

Theoretical sources

Law (1986, 1994) describes stories of the social world as “stories of order” (p. 9). He suggests a path of sociological modesty that “violates most of the inclinations and dispositions that we have acquired in generations of commitment to the scientific method” (p. 9). If, as Law suggests, our ordering is never complete, then there are new ways of understanding nursing practice, new understandings that are different than the “passed down clothes” of traditional assumptions and prevailing discourses and commensurate authority claims.

Giddens (1976, 1977, 1979, 1984, 1987), using the word “structuration,” suggests that social relations are structured across space and time. “Human social life may be understood in terms of relations between individuals moving in time-space, linking both action and context, and differing contexts with one another” (Giddens, 1987, p. 147). By examining the way in which work is organized or how the work is done, the actions of actors serve to reveal the structures [contexts] that impact these actions. I am therefore interested in how context or structures influence practice.

Thesis layout

The thesis consists of two parts. Drawing on the work of Foucault, Garfinkel and Giddens, the first half of this thesis develops the site for the study: an examination of how organizational and leadership discourses have been conceptualized and influence nursing education, administration [nursing leadership] and clinical practice activities. This exploration involves a critical review of the ways in which health care organizations in Canada have been constructed and how changes or so called health re-forms are written and researched. Chapter Two examines Foucault’s understanding of governmentality and how actions have shaped an economic, efficiency view of health care, and contributed to current technologies of division prevalent in health care organizations. The process of an organizational change that occurred in the clinics in this study will be outlined.

Chapter Three explores the conceptual frameworks that are espoused to guide oncology specialty practice. The contradictions in these claims are explicated and the competing aims are exposed for critique. I advance an argument that oncology nursing practice is only partially explained by the current conceptualization of that practice. The particular conceptualizations that have been taken up by nurses create a space to practice

that affords them a form of professional recognition governed by their professional leadership structure. I further explore how taking up these particular conceptualizations of practice serve to constrain other possibilities for practice.

The second part of the thesis entails presentation and analysis of research material drawn from an ethnographic study conducted at two cancer clinics in Western Canada. Three chapters develop observation of cancer clinic interactions in the ambulatory care setting and organizational documentation. Chapter Four provides a description of the setting and the participants in the study. Chapter Five outlines the methodology and method of analysis undertaken in this study. Chapter Six examines the ambulatory clinic visits and explores those practises that are routinized and proceduralized. Chapter Seven is a more in-depth examination of the ambulatory visits focusing on the relationship between nurses and physicians, and patients drawing on the accounts of nurses within interviews, their written records, and observations of their interactions with each other, their patients and from observations of doctor-nurse-patient interactions.

Chapter Eight explores a new patient appointment and theorizes the conduct of specialized nursing practice drawing on ethnographic materials specifically the observational material with respect to nurses' accounts within interviews, their interactions and nurse documentary records. Chapter Eight also draws on the nurses' accounts within interviews together with observations of them at work and explicates the practice methods and knowledge that nurses say they use that demonstrates the expert nature of their practice.

Following Latimer (1993) "treating the research material in this way considerably extends the discussion beyond evidencing a more direct statement of findings" (p. 2).

Latimer suggests, and I concur, that presenting the material in this way provides an interesting way of examining the topic, captures the texture of cancer ambulatory care life and provides the reader with a "broad overview of the site prior to moving to a more general discussion of findings" (p. 2). In the final chapter, the important aspects of the study are summarized and relationships between the findings in the study and implications for nurse leaders and suggestions for wider organizational considerations are explicated.

Methodology

Study focus

Much has been written about change in the nursing literature. According to Copnell (1998), since 1982, 2500 articles related to change have been indexed in the Cumulative Index of Nursing and Allied Health Literature (CINAHL) (p. 2). Copnell indicates that few of these relate to changes in clinical practice. Many articles related to broad organizational changes, but did not focus on the impact of these changes on clinical practice. One of the intentions of the change initiative, studied in this dissertation, was to re-organize the work and role of nurses within the ambulatory settings, and so developing a methodology that could trace practices changes is imperative,

Oncology speciality nursing practice is developed in the study as a discursive and practice space, a 'site.' The purpose of this exploration is premised on the belief that in order to contest the taken-for-granted narratives and beliefs regarding oncology practice it is necessary to develop a "thick description" (Geertz, 1988), of oncology nursing actions or conduct. In this study, practice is taken to be an aspect of nurses' conduct.

This study focuses on oncology nurses' practises in a broad context that can be construed as a culture that can be explored and written as a text in the ethnographic sense.

Rosaldo (1989) suggests that "culture lends significance to human experience by selecting from and organizing it" and that we can only learn about other cultures by reading, listening or being there (p. 26). Street (1992) indicates,

The discipline of nursing, like any discipline, holds shared common meanings concerning taken-for-granted knowledge about how things are understood and done. These meanings make up what it means to be a nurse and, therefore, powerfully and profoundly penetrate nursing culture (p. 267).

In this study, the culture of oncology nurses is explored and the influences of the organizational change, nursing leadership and speciality practice are explicated. A critical aspect of the social nature of oncology practice is the language systems utilized to account for that practice.

Language

What counts in the things said by men is not so much what they have thought or the extent to which these things represent their thoughts, as that which systematizes them from the outset, thus making them thereafter endlessly *accessible to new discourses* [my emphasis] and open to the task of transforming them (Foucault, 1972, p. xix).

A critical perspective on language does not take language at face value (Adams, 2001; Oates, 1995). The relationship between words, meanings and how meanings are attributed to actions or persons or places, encompass historical, cultural, social and political influences. Foucault (1972) suggests that language is more than linguistic facts. Language as discourse over time shapes and forms the meanings that are constructed regarding social phenomena. Beyond this, as the quotation above suggests, language structures possibilities for developing meanings. Discourse and practice are taken by me to be socially discursive phenomena.

The nursing profession accounts for practice through the discourses of science, theory, experience, expertism and professionalism (Fawcett, 1999; Gortner, 1980; Johns, 1995; Tomey, 1998; Tomey & Alligood, 1998). The language of nursing practice is more than the description of that practice. Language is not separate from practice as according to Purkis (1993), language “constitutes action in particular ways and affects understandings of action” (p. 4). In order to develop an understanding of how nursing practice has come to be understood, how nurses are “accessible to the new discourses and open to the task of transforming them,” it is critical in this study to layout the various language systems that contribute to, influence and compete with nurses’ discourses and practises (Foucault, 1972, p. xix). This study explores how the language of oncology nursing practice has been taken up, by whom and for what reason.

In the organizational restructuring initiative the role of primary oncology nurse was identified as a key practice change and role for nurses. I explore how this particular representation of practice, primary nursing, was taken up by oncology nurses in one clinic in the organization and was virtually ignored in the other clinic. An examination of the documentation related to primary nursing reveals that the direct measures of patient benefit stated in the therapeutic aims of oncology primary nursing disappear as nurses attempt to explicate their practice in keeping with competing conceptual frameworks.

Foucault (1972) indicates that behind the dominant discourse of everyday [practice] lie the rules that bind that activity. The practice of oncology nurses is bound by the dominant discourses that have been taken up by oncology nurses in order to explicate their practice and construct a space to practice. Heslop (1997) suggests that the concerns of discourse inquiry are with “intertextualism, which involves the generation of

new positions to resist or question regarding existing discourses” (p. 54). The discourses of oncology nursing practice are constitutive of both the dominant visible discourses and the subjected, local discourses. In exposing the local subjugated discourses, a new understanding of what accounts for nursing practice is exposed. Revealing what lies behind the discourses opens up the opportunity to explicate how oncology nurses have come to construct a space to practice and the knowledges behind that construction.

Knowledge/Power

Foucault (1972) was interested in exploring practices that produce notions like those of absolute truth and absolute knowledge. He was not concerned about the notion of truth as absolute or about methods to acquire truth. Rather, he contended that knowledge is constructed and interpreted in relation to historical factors. His work suggests that the methods developed by Descartes would have been constructed differently had they occurred in another historical era. He maintained, “we are not autonomous subjects defined by intrinsic nature, subjects that passively entertain ideas which may or may not represent inaccessible objects or inferential knowledge” (cf. Prado, 1992, p.108). Rather, we are shaped by our personal histories and our knowledge is “manufactured [and] produced by our discourses and practices” (p. 108).

Foucault (1972) indicates that these products of practice and discourse [knowledge] are interrelated with relations of power. The concept of power-relations is a fundamental assumption in Foucault’s work. Power-relations are more than power by itself, instead implicating a “complex system of relations” (p. 110). Power can be “localized, dispersed, diffused and typically disguised through the social system, operating at a micro, local and covert level through sets of particular practices” (Turner,

1997, p. xi). Following Foucault, this study is interested in revealing the system of relations and sets of practises in the cancer clinics in order to understand how power constructs particular relations through which organizational change is accomplished and understood as being successful or unsuccessful by nurses

“Each society has its regime of truth and genealogy is interested precisely in how we govern ourselves and others through its production” (Foucault 1980a, p. 131). McCarthy (1992) suggests in these regimes of truth, certain discourses are privileged, ways of distinguishing true from false statements are sanctioned, and those that utilize these truths have a certain status. McCarthy indicates that there is a “political economy of truth, as there is of any organized social activity” (p. 251). In other words, what we take to be the truth is much more complex than the taken-for-granted assumptions that we often attach to those things that we know to be true. Truth, like other social activities, is actively produced in the context of practice. By exploring practice truth claims, one can begin to understand how particular knowledge truths have come to be constructed, understood, and what has influenced those understandings. Knowledge for Foucault occurs in relation to what can be said at a particular time. Fundamental to the notion of truth is the interrelationship of power and knowledge.

Foucault utilised a genealogical approach to examine the ways “in which power relations are both conditions and effects of the production of truth about human beings” (Kelly 1994, p. 250). This approach traces back through history the roots of a subject, for instance sexuality and medicine, and by examining the language or discourses that are used to describe a practice, one can reveal how we have come to think particular thoughts about a subject. However, Foucault (1976) does not suggest that what is revealed is truth,

rather, “whatever we take to be truth and knowledge are what they are because of history and power-relations” (p. 121). This challenges not only the notion of one truth that Western Society has consistently relied upon against evidence to the contrary, but also suggests that truths change as a result of influences of both practices and talk about those practices at a particular time. This is a much more mobile sense of truth and yet it should not be understood as merely relative nor amoral. Rather, for Foucault, truths are tightly bound to local moral conditions that are constantly in conflict with wider moral modalities that seek to generalize, standardize and economize.

Foucault’s study of medicine provides a powerful example, of how what we believe about certain subjects came to be constructed, the continuing influence of those beliefs today, and that actions ‘somehow’ find a way through.

Authoritative knowledge

The production of medical knowledge and the commensurate authority or power claims of medicine today are seen to be based on contemporary knowledge and beliefs. However, a genealogical exploration of these knowledge claims reveals something quite different. Foucault’s examination of medicine discussed in The birth of the clinic (1973) provides an example of how disciplines such as medicine have developed and maintained their power through knowledge. Exploring how medical knowledge came to be produced, Foucault maintains,

For clinical experience to become possible as a form of knowledge, a reorganization of the hospital field, a new definition of the status of the patient in society, and the establishment of a certain relationship between public assistance and medical experience, between *help and knowledge*, became necessary; the patient has to be enveloped in a collective, *homogeneous* space [my emphasis]. It was also necessary to open up language to a whole new domain: that of a perpetual and objectively based correlation of the visible and the expressible (Foucault, 1973, p. 196).

This prompts the question of how the human subject took itself as the object of possible knowledge. Foucault suggests that, through the rationality of positivism and the historical context of the seventeenth and eighteenth century with the advent of surgical dissection and pathology, a new discourse of medicine was defined that took up the notion of saying what one sees. Techniques of observation, dissection, classification of illnesses, symptoms, and internal body parts contributed to a new science that was based in part on making visible the invisible or “the interior revealed” (p. 196). This new knowledge of medicine positioned the body [patient] as objective and thus a subject for study or for “new techniques of power – disciplinary power” (Peterson & Bunton, 1997, p. 5). Foucault states that disciplinary power,

is exercised through its invisibility; at the same time it imposes on those whom it subjects a principle of compulsory visibility. In discipline, it is the subjects who have to be seen. Their visibility assures the hold of power that is exercised over them. It is the fact of being constantly seen, of being able always to be seen, that maintains the disciplined individual in his subjection. And the examination is the technique by which power, instead of emitting the signs of its potency, instead of imposing its mark on its subjects holds them in a mechanism of objectification. In this space of domination, disciplinary power manifests its potency, essentially, by arranging objects. The examination is, as it were, the ceremony of this objectification (1984, p. 199).

In other words, patients are the subjects of scrutiny and study by nurses and physicians. Patients are objectified by the techniques that are exercised by care providers, such as physical examination. These techniques position patients as passive and vulnerable to the ‘disciplinary power’ of those who appear to have the ‘right’ to unearth features about the patient that are not immediately accessible, such as signs and symptoms.

Foucault, holding up disciplinary power against judicial power indicates that disciplinary power “is human science which constitutes their domain and clinical knowledge their jurisprudence” (Foucault, 1976, p. 44). In other words, the clinical

knowledge of medicine acts similarly to legal knowledge in the court system. The objective “gaze” of the physician was intended to expose the invisible body in a manner that broke away from “theories and chimeras” (Foucault, 1973, p. 195). In doing so, the social context of the patient was stripped away and the patient as an individual gave way to the view of patients as “homogeneous.” Thus homogeneous patients became the objects of those who were seen to have the “knowledge to help” them. “Helping” in the health care sense became inextricably connected to “knowledge.” The objectification of patients rendered them accessible to the disciplinary power of the physician and the medical gaze.

The birth of the clinic is illustrative of the Foucauldian ontology of knowledge and power relations. Foucault seeks to uncover the truths revealed by various knowledge claims. He views power not as negative, but, rather, as productive. Foucault states,

“We must cease once and for all to describe the effects of power in negative terms: it excludes, it represses, it censors, it abstracts, it masks, and it conceals. In fact, power produces, it produces reality, it produces domains of objects and rituals of truth” (1977, p. 194).

Therefore, in my examination of nursing practice, following Foucault, the question that frames this study is more related to identifying the “specific practices that characterize the ways in which power relations function within the organization” (McHoul & Grace, 1993, p. 65), to produce particular sorts of opportunities for oncology nursing practice.

Subjugated knowledge

Foucault indicates that in critically examining practices, one must look beyond what has come to be known and spoken of as knowledge and look further to reveal subjugated knowledges. “Subjugated knowledges are those blocks of historical knowledge which were present but disguised within the body of functionalist and

systematizing theory and which criticism – which obviously draws upon scholarship – has been able to reveal” (Foucault, 1976, p. 21). I endeavour in this study to illuminate the subjugated knowledges of the nurses and patients that have given way, over time, to dominant scientific knowledge and discourses.

Foucault (1976) indicates that it is against the effects of the power of [scientific] discourses that “genealogy must wage its struggle” (p. 23). In other words, buried beneath the dominant scientific knowledges of, for instance, medicine laid the subjugated knowledges of individual practitioners, doctors, nurses, and patients. He suggests that by critically examining these knowledges, one is able to reveal the systems, structures and relations operating to perpetuate their existence. For instance in the cancer clinics, the system for classifying patients can be construed to be based on knowledge, rooted in positivist science. However, a critical examination of the practice of classifying patients reveals that this also serves to order the clinic and the relationships between physicians, nurses and patients. Therefore what might be considered a logical way of talking about patients takes on a truth that negates the knowledge those individual patients or practitioners might have brought to the situation. Foucault (1976) describes this knowledge as “naïve knowledges, located low down on the hierarchy, beneath the required level of cognition or scientificity” (p. 21).

Street (1992) suggests that the “hegemonic hierarchical order of claims to ownership of legitimate knowledge not only supports the dominance of medicine but has been used historically as a mechanism to de-skill other health disciplines” (p. 39). This is not to suggest that medicine dominates nursing, rather the knowledge of medicine situated in scientific discourse dominates all actors in the health care system including

doctors. In this study, the knowledge premises of the organizational change and the dominant truth regime of scientific medicine are critically examined with a focus on revealing who and what is being served by their domination. In order to make changes to practice it is important to understand how knowledge related to practice has come to be understood now, and the relations that occur within these particular understandings.

Street (1992) provides an example of how hegemony was daily recreated and maintained by nurses in her study. Street suggests that many of the practices that nurses engage in are done so with unquestioning acceptance. When challenged to explicate the actions and behaviours related to for instance, taking breaks, nurses were able to “uncover habitual ways of thinking and acting and the historical processes that create and constrain hegemony” (p. 220). In other words, nurses, like others take up discourses for particular reasons, and they silence others. Foucault suggests that in opening up the silenced knowledge, or local knowledges, one can come to understand the “historical knowledge of struggles and to make use of this knowledge” (p. 22). A critical reading of the practises of oncology nurses serves to unearth the power/knowledge relations embedded in these practices. Understanding these relations is essential for nurses and nurse leaders as they negotiate the continuous bombardment of changes that are occurring in health care and make determinations related to these.

Street (1992) indicates that acts of resistance by nurses to the hegemony of oppressive situations can bring about transformation. She goes on to suggest that in the transformation, by revealing the hierarchies of knowledge, nurses might work towards shaping their work in a manner that values their knowledge and contribution. I dispute this contention and instead, following Foucault, suggest that it seems unlikely that the

local knowledges of nurses can be surfaced in a sufficient manner to change or remedy what they may, or may not, consider oppressive. I would suggest that many different groups, including administrators, government, physicians, and nurses themselves, wish to see nursing practice conducted differently. However, by revealing the subjugated knowledges of nurses and offering this back to practice, one would have the opportunity to see if laying these transparent has any effect. At the very least, changes to nursing practice would not merely be based on the good intentions of administrators, but also would be informed by the organized and organizing knowledges of nurses. In order to explore knowledge in this way, a particular conceptualization of practice must be explicated as available for use in an empirical study of oncology nursing practice.

Management discourses

Nurses in practice are influenced by a management discourse that emphasises the need for increased efficiency in all practice domains including that of nursing. This often involves turning to an organisational requirement for documentation (Hughes, 1990; Klakovich, 1994; Reverby, 1987). For example, the implementation of workload measurement tools necessitates the documentation of nursing care in relation to specified tasks. The classification of nursing care in a task list conflicts with the purpose of many of the theoretical models that promote the documentation of nursing practice in accordance with specific theoretical language. The classification of nursing work presupposes an instrumental rationality in the understanding of nursing care (cf. Habermas, 1984), an interest based on a value of prediction and control. This type of technical rationality is premised on a taken-for-granted view of nursing as a profession positioned to attend to technical types of issues and perform tasks.

In the past and indeed currently, nurse leaders believe that an analysis of workload is a bona fides mechanism to demonstrate the value of nursing. They can be seen as contributing to the goal of efficiency (Snelgrove & Hughes, 2000). This requirement of employers to document in this manner perpetuates the “traditional view of nursing as an essentially practical occupation learned via a form of on-the-job apprenticeship and concerned with technical-medical tasks” (Snelgrove & Hughes, 2000, p. 66).

Foucault (1977) maintains that hierarchical organisations require some form of surveillance, to check that things go on as they should be going on according to prescribed goals and procedures. Foucault (1977, 1980a) captures the self-disciplining effects of surveillance in his analysis of the way in which the panopticon was designed, as a technology of surveillance. The panopticon designed by Bentham is a circular prison with individual prison cells arranged in such a way to enable observation of each cell by one prison guard. The guard can see the prisoners, but they cannot see him/her.

Hence, the major effect of the panopticon: to induce in the inmate a state of conscious and permanent visibility that assures the automatic functioning of power. So to arrange things that the surveillance is permanent in its effect, even if it is discontinuous in its action; that the perfection of power should render its exercise...in short that the inmates are caught up in a power situation of which they are themselves the bearers (Foucault, 1977, p. 201).

Foucault suggests that through practises and technologies, physical surveillance may be minimized, as self-discipline takes up the effect traditionally seen to be produced through the eyes of the guard. Further, Foucault indicates that many institutions such as hospitals, and schools are panoptic.

Street (1992) suggests that the panoptic metaphor is applicable to nursing and uses the wearing of a uniform as an example of how “nurses become objects of power

which is constituted and maintained through hierarchical surveillance” (p. 147). She goes on to explicate how nurses themselves participate in their own policing, thus “contributing to their own oppression” (p. 154). Cheek and Rudge (1994) suggest that an examination of nursing and associated health care practices provide many examples of surveillance techniques being employed in the name of tests and diagnostics.

Leadership discourses

Following Foucault (1970, 1972, and 1975), the discourse of nursing leadership is less evolutionary and more contingent on the historicosocial context of the era being examined. In the late 19th century, the influence and discourse of religion and duty to service shaped the actions of nurse leader (Maggs, 1980; Maggs, 1983; Maggs, 1987; Maggs, 1996). In the early 20th century, the discourse of poverty, class and the position of women in society influenced the direction of nurse leaders (Dean & Bolton, 1980; McPherson, 1996). The growth of hospitals, two world wars, the primacy of medicine and the dominant discourse of science all impacted the manner in which nurse leaders perceived and enacted their roles. A critical reading of the contemporary nursing literature reveals contradictions and incongruencies.

“Many authors have explored the traits, characteristics, styles, roles, strengths and weaknesses of nurse leaders and managers” (DeSimone 1996, p. 112). These explorations over time reveal a variety of broad management skills identified as integral to the role of nurse manager/leader, including fiscal/budgetary skills, human resources management, communication patient care management (Hall & Donner, 1997). A 1992 study by the American Organization of Nurse Executives (AONE), identified six functions of nurse managers including; management of clinical nursing practice, human,

fiscal and other resources, development of personnel, compliance with professional standards, strategic planning and fostering of collaborative, interdisciplinary relationships. Hall and Donner (1997) are critical of many of these studies as they suggest that they reflect only the characteristics of the manager role without exploring the behaviours necessary to carry out the role.

The attributes of nurse leaders have been explored by a variety of authors. Oroviogicoechea (1996) suggests that the skills and knowledge of nurse managers are contingent on the environment in which they are required to perform. She utilizes a framework developed by Katz (1974) that indicates that organizations require different skills and characteristics depending on the specific organization and the position which the person is in. The three major skill sets characterized by Katz, are, technical, human and conceptual skills. Chase (1994) utilized Katz framework in a review of the literature to categorize the skills of managers and added leadership and financial management skills to those previously identified.

Manfredi (1996) explores the manner in which nurse managers apparently demonstrate leadership qualities. Through her study she indicates that although the activities of nurse managers were consistent with those described by the literature, they were more inclined to be circumspect, employing short-term goals rather than developing a long-term vision. Manfredi suggests that congruence with the manager's short-term goals and organizational vision is necessary to motivate nursing staff to work towards achievement of the vision. The question that this provokes is whether or not it is the leadership skills of the manager or the congruence with the health care organisation's vision, which prompts the nursing staff to work towards a common goal.

Orovioioicoechea (1996) indicates that it is a combination of both. She suggests that in the rapidly changing health care organizations both human and leadership skills are crucial.

Ferguson-Pare (1997) describes a variety of leadership attributes that contribute to and promote the autonomous decision-making and professional practice of nurses. These include, support and recognition of staff, input, feedback, involvement in decision-making, and use of vision. These findings are congruent with other descriptors of desirable leadership attributes and the resulting apparent positive effects on nursing staff (Dunham, & Fisher, 1990; Dunham & Klafehn, 1995; Dunham-Taylor, 1995). The positive effects include satisfaction with autonomy of practice that results in job satisfaction and apparent positive quality of care outcomes. A critical review of these studies reveals a reductionist and decontextualized view whereby actions of individuals can be broken down into characteristics. The term transformational leadership has been used to capture many of the attributes previously discussed and is touted as essential for empowering others and achieving a shared vision (DeSimone, 1996; Skelton-Green, 1995). DeSimone quoting from Burns states that transformational leadership is a “process by which leaders and followers raise one another to higher levels of motivation and morality” (in Burns, 1978, p. 20). This type of leader apparently contributes to an environment that motivates others.

Nurse leaders are often called upon to account for nursing practice. Such interpretations of nursing practice by nurse leaders are problematic, as according to Foucault (1972), “data supporting varying interpretations and conclusions are themselves products of interpretation” (p. 116). The interpretations of nurse leaders have the

potential to condition and shape, “not only what we conclude from evidence, but what sort of things or events we deem to be evidence” (Foucault, 1972, p. 161). The implication here is that the interpretations or discourses prevalent in health care organisation influence the way in which nurse leaders understand and interpret nursing practice. For instance, the discourse of business and deficit management in Canadian politics contributed to the prevalent economic view of health care rather than a view of caring for the sick. Nurse leaders who take up the business language of health care and account for practice in this manner contribute to a hegemonic economic view of health.

The Site for the Study: Practice

Post-structuralist inquiry

An examination of nursing practice informed by a post-structuralist methodology seeks to understand the rules [often unspoken and taken for granted], structuring activities, interactions and experience in that social space. Some of these rules might be written; others are embodied in the unwritten but *powerful code of the way things are done* [my emphasis] (Jacques, 1993, p. 49).

In order to untangle the written from the unwritten, the spoken from the unspoken, the variety and complex interactions of patients/nurses/leaders, one needs to examine “practice in the making, rather than ordering or cleav(ing) order and the taken-for-granted assumption that certain phenomena do not require explanation” (Law, 1994, p. 7).

Following Law (1994), in approaching this study, I did not attempt to determine “a priori” aspects of oncology nursing practice to privilege or assume “that there are certain classes of phenomena that don’t need to be explained at all” (p. 10). In exploring the “messy complex social world” of oncology nurses, I do not act with an authoritative definition of that practice, but rather seek to describe how nursing is accomplished in the everyday and probe and unpack the “powerful code of the way things are done” (p. 10).

Setting

The site for this study is in the practices of oncology nurses, as these are conducted in two cancer clinics in Western Canada. Nursing practice and discourses are socially discursive phenomena. Practice is taken to be more than simply action as there is meaning given to those actions, "within a social network that can itself be read as if it were text" (Jacobson & Jacques, 1997, p. 48). Nursing practice does not occur in isolation within organizations and there is a fluidity of practice that I take to be influenced by the structuring effects of language, and influenced by myriad activities. "Practice and processes in organizations have a discursive aspect in that they are constructed to fit the situation and system of discourses" (Bilmes, 1986, p.7). In examining nursing practice, utilizing field methods informed by the epistemology of ethnography and ethnomethodology, I am able to expose how it is that oncology nurses have produced their practice world and how that production interacts and intersects with the produced world of the patients they care for. An exploration of the following questions provides a rich description of oncology nursing practice and provides leaders with a new and different understanding of how that practice is constituted and enacted. The following frame this study.

Purpose

Through a contextualized understanding of practice, the purpose of this research is to explicate relationships operating between leaders of nursing practice, practitioners and patients/families, and how these, in turn, recursively reproduce forms of nursing practice.

Questions

1. How, within such a context, would a leader know that practice is being changed or improved and what might account for such change/improvement?
2. How can leadership practice operate to resist consensus and instead, foster the inclusion of conflicting knowledges that recognize differences in position and knowledge of practitioners, patients/families and managers?
3. What effect do such conflictual spaces have on discourses of knowledge and the expertise of selected oncology nurses?

Summary

This chapter has introduced the setting, topic under study, and the conceptual and theoretical framework that inform this study. The study takes place in two cancer clinics in Western Canada that have undergone a significant organizational restructuring. Oncology specialty nursing practice is the topic under study and is developed as a discursive and practice space, a site. Foucault is introduced and his conceptualizations of authoritative knowledge, power, and language provide an analytic position from which oncology nursing practice can be studied.

To borrow the “passed-down clothes” metaphor from Gardner in the beginning of this chapter, this study aims to explore questions and put forth views that will provide nurse leaders and nurses with a suit of clothes or ideas that better fit oncology nursing practice. These clothes [ideas] are designed to provide different perspectives on how it is that oncology nurses have come to enact their practice in the context of an organization that has undergone a significant restructuring. Reading the text of practice by an examination of practice-in-action leads to understandings that are different than the

scripted discourse of oncology practice depicted in the literature. Lather (1991) indicates that “we are both shaped by and shapers of our world” (p. 8). This study is concerned with how it is that oncology nurses participate in shaping their practice world.

The next chapter examines the organization of health care in Canada, and the influence of governmentality on the movement from a concern about health care to delivering types of services resulting in a technology of division. Various health care reforms and the cancer clinic restructuring initiatives are explored to explicate the espoused impacts on the practice of oncology nurses.

Chapter Two: Technologies of Division

What citizens consider natural, neutral and universal are simply *impositional claims* [my emphasis] which are assertions about reality which are self interested, biased, historically-specific and thus subject to political contestation. These claims provide the cultural foundations affecting the kind of state that governs a particular society (Brodie, 1995, p. 27).

Introduction

Health care organizations in Canada are said to be under siege as they grapple with rapid advances in technology, burgeoning patient populations, and significant economic pressures (Armstrong & Armstrong, 1996, 2003). Policy-making in relation to healthcare services has moved from concerns about public health to the delivery of types of services. The preoccupation with funding various types of services and containing costs has spilled over into organizations that are caught up in making continuous changes in an effort to meet ‘bottom line targets’. I will briefly explore the significant changes that have occurred in health care in Canada since World War II to illustrate how the “impositional claims” of government have become woven into the fabric of organizations in the name of improving health care. Then, following Foucault’s understanding of governmentality, I will advance an argument that actions such as health care reforms and the organizational change initiative of interest in this study affect (i.e., govern) and shape the conduct of health care organizations with cancer clinics and also health care practitioners, in this case the nurses (Gordon, 1991). It is my contention that a technology of division has contributed to how care delivery has been conceptualized and enacted.

The organizational change initiative at the cancer clinics will be presented as a case study that provides the frame or context for discussions about oncology nursing practice. This change initiative demonstrates many of the discourses that have typically

been taken up by health care organizations in the 1990s and their impact on the provision of health care.

Governmentality

Foucault (1991) explores the conceptualization of government from the 16th century. He discusses the shifts in governmentality from the feudal type of territorial regime, or a society of laws, to an administrative state, or a society of regulation and discipline, and finally to a governmental state, which bears essentially on managing the population and the institutions, organizations, and processes which that population encompasses. Foucault (1991) extends the conceptualization of government to include activities that affect the conduct of individuals. Hindess (1996), based on his reading of Foucault, argues that in,

Foucault's view the government of societies takes place in a variety of state and non-state contexts. The family, for example, can be seen not only as a potential object of government policy, but also as a means of *governing* the behaviour of its own members. Similarly, accountancy and psychiatry can be seen as *regulating behaviour* in ways that interact with, but are nevertheless distinct, from, regulation through the making and enforcing of laws [my emphasis] (p. 107).

In other words, governmentality is not restricted to that realm of activity typically described as formalized government but is extended to other "governing" activities. Governmental power is also extended to activities that reach far beyond that of laws. Activities of "regulation" could include [formal] governmental policy, organizational policy, professional standards and so on.

Bjornsdotti (2002) uses Foucault's idea of governmentality in an exploration of care giving in the home in Iceland. Bjornsdotti suggests the shift of responsibility for the "health and well-being of the nation" from the state to the individual affects not only the behaviour of citizens but also that of nurses in practice (p. 3). Nurses are caught up in the

official 'policies' of shifting care from the formalized health system to families. Likewise, Purkis (2001) describes the shift in home nursing care in one city in Canada that focuses on shifting services for chronically ill patients. This shift in focus is characterised as 'better' for everyone and is linked to the need to do things differently, as the current way proposed is not sustainable. Both of these examples point out the applicability of Foucault's concept of governmentality, as the behaviour or actions of nurses are impacted by managerial policies and procedures. These technologies discipline nurses to act in particular ways.

Hindess (1996) suggests that disciplinary techniques explicated by Foucault (1977) such as education and training, military organization, the regulation of hospitals and so on, would in his later writings be called government. That is not to say, that discipline, as governmental power, is only exercised within these circumscribed contexts. Rather, Hindess indicates that "discipline itself is regarded in society as a generalizable technology of government, one whose use is not confined to any particular techniques or institutional setting" (p. 117). I suggest that using this view of governmentality and governmental power extends the discussion of how changes in government and organizational activities have served to govern or discipline the activities of health care practitioners. This serves to alert us to look beyond accepted disciplinary features, such as laws that prohibit harm, as the sole means of regulating society. Instead the notion of governmentality encourages an analytic perspective whereby discourses of "professional autonomy" and "patient choice" can be investigated for their own regulatory, and ultimately economic effects. These readings of organizational change will be explored more fully in chapters six and seven.

The Politics of Healthcare in Canada

Post World War II

The 1940s and 1950s in North America were socially characterized by the growth of everything! The returning servicemen and families were consumed with creating a new reality, one, which would serve to block out the war experience. Governments were exceedingly willing to meet their needs. Government agencies grew and the need for finding new ways of managing these organizations also flourished.

Hole and Levine (1979) state, “the development of organizations is the principle mechanism by which, in a highly differentiated society, it is possible to get things done, to achieve goals beyond the reach of the individual” (p. 3). They suggest that the need to structure work, and therefore the workforce, for economic benefit has been a topic of discussion from the time of the ancient Greeks to the present day. While early organizational theorists focused on the structure of organizations, the post war era demanded a reworking of the then dominant discourse of organizations.

In the realm of health care in Canada, prior to the end of World War II there were a number of ways in which federal, provincial and municipal governments invested money. These health care programs were not widespread and were not universal or equitable. Brodie (1995) describes that the changing role of the state post World War II “engendered widespread public expectations that the government was responsible for meeting the basic needs of the citizens” (p. 15). Expectations were met by the government implementing various universal social welfare programs such as family allowance, and universal primary and secondary schooling. Health care was also included in the strategies to provide social security or a social safety net for Canadians.

In the Report on Social Security for Canada, Leonard Marsh makes it clear that the social safety net was about the collective pooling of risks as a result of the devastation experienced by many during the depression and war years (1975, p. 9). During the recruitment of troops for the War, it was revealed that Canadians were not in good health and post war there was a need for healthy workers to build the economy. Therefore, the government of that day recognized that investing in health care was an investment for the future health of the economy. In this context, health care could be considered a commodity necessary to ensure the economic viability of the nation, rather than merely a social institution with the goal of benefiting individuals. The original intent appears to have been to heal the wounded soldiers and return deprived citizens to health, but not necessarily to commit to structures that would be ongoing, for instance, to health care organizations and institutions.

Armstrong and Armstrong (2003) indicate that initially the components of health care that were targeted in Canada for universal implementation were in the public health realm for example, well baby clinics, immunization programs, regulation of drugs, and sanitation services. The provinces, by law, were responsible for most aspects of health care although taxation was the jurisdiction of the federal government [state]. Although the provinces agreed that the state's role in health care needed to be expanded, there was no agreement on how that might be achieved. In 1948, a national health grants program was initiated which committed the federal government to half the costs of hospital construction. This resulted in an enormous increase in the number of hospitals that opened up a space for medicine and nursing to move into to.

Institutionalized Care

Technological surveillance

Nursing in the home was the prevailing accepted mode of nursing practice until the mid 1800s (Bunting & Campbell, 1990; Morgan & Marsh, 1998). The movement of nursing from the home to the hospital setting was influenced by the physician's need to practice in hospitals in order to make use of expanding medical technologies, techniques, and procedures. The emphasis on disease care shifted the focus of public health nursing from health promotion to disease prevention (Kulbok, Baldwin, Cox & Duffy, 1997; Novak, 1988).

The increase in numbers of hospitals after World War II opened up space for medicine and nursing to move into. Foucault (1973) examines the advent of hospitals and clinics, and reveals, "the hospital became viable for private initiative from the moment that sickness, which had come to seek a cure, was turned into a spectacle" (p. 83). Help and knowledge as explicated in chapter one became inextricably connected in the name of caring for the sick. "Helping ended up by paying, thanks to the virtue of the clinical gaze" (p. 85). Hospitals, paid for by the state [rich] benefited the sick [poor], but also benefited the rich by "making possible a greater knowledge of the illness with which he himself might be affected" (Foucault, 1973, p. 84). In other words, patients were seen to benefit from health care practitioners who, in turn, were seen, by the general public, to benefit due to knowledge acquisition.

According to Foucault both the rich and poor "participated in the organization of the clinical experience" (p. 85), the poor by subjecting themselves to the investigations [medical gaze] of physicians, and the rich by providing the structure [clinic] within which

to conduct the investigations. Currently, clinical care continues to be organized in increasingly complex organizational structures [hospitals] and patients continue to be the subject of the medical gaze. In cancer care, the development of new drug regimes depends upon the enrolment of patients in clinical trials. Thus patients receive the medical gaze in the name of research and knowledge generation. In turn, patients on clinical trials are afforded the opportunity to try out the newest and latest drug technologies. An uncritical view of clinical trials would suggest that both patients and science benefit. However, the economic benefit to drug companies cannot be ignored, and patients are used to contribute to the economic well being of drug companies.

Another clinical example of how the medical gaze, or surveillance, is played out in the current health care system is found in studies by Pryce (2000, 2001). Following Foucault (1980b), Pryce explores the disciplinary power of the medical gaze and describes the themes that are relocating the active patient as the central object of health scrutiny by professionals. Pryce suggests that the practices in a genitourinary clinic of “elaborate techniques of interview and inquisition developed through the deployment of disciplinary knowledge has powerful contemporary resonance within clinical nursing, and sociological practice” (p. 107). Pryce goes on to describe how the practices of medical examination, specimen collection and accompanying disclosures that occur during clinic visits construct the patient as both self-monitoring and self-observing. He indicates that all of these activities influence how it is that patients view themselves and how both health care professionals and society at large view them. Pryce uses parallel examples of sexual practices that were considered normal during the pre-AIDS era and how these have now been re-constructed in the language of risk.

From an organizational perspective the gaze also impacts the conduct of health care professionals. Where there is hierarchical organization there is a need for inspection and examination, that is, of surveillance. Foucault's (1973) work suggests that surveillance affects conduct in the presence of other understandings, such as are implied in the idea of rules of conduct or protocols for practice. New technologies are developed that are aimed at an economy of effort and thus surveillance is facilitated. The physical layout of hospitals and clinics are designed to save both patients and staff from having to move from place to place for care. In one of the clinics in the study, the clinic areas were designed with small waiting areas that can be viewed by the clerical desk. The purported intention of the design is to create smaller waiting areas that are not so crowded with patients. I suggest that these waiting areas are also designed to increase the surveillance capabilities of the staff, as they are able to see at a glance whether the patients booked for clinic appointments are in the waiting area or not, if they are early or if they are late.

Physician as expert

The emerging publicly funded Canadian health care system of the 1950s, 1960s and 1970s reflect the dominant ideology of the so-called medical model. The enormous increase in hospitals paid for by the state reinforces the belief that institutional care delivered by physicians will meet the health care needs of Canadian citizens. The funding formula insuring services provided by physicians entrenches the hierarchical organization of care in hospitals and the power of the physician at the top of the hierarchy. The political discourse regarding health care in the post World War II era is situated in what is described as *allopathic medicine*. The fundamental assumption of this view is the belief that illness is biological and body part specific. The goal is curative

through the science of medicine and the physician is the expert and authority. These beliefs form what Bowers (1984) refers to as a taken for granted assumption of society. These taken for granted assumptions are imbedded in Canadian society and serve to shape the manner in which health care services are developed, delivered and perceived by the Canadian public.

The physician acts as gatekeeper and the prevalent fee-for-service payment plan reinforces the body part notion of health. "The power of the physician is based on the idea of [the] doctor as expert, the objective, knowledgeable person who applies proven diagnosis and techniques" (Armstrong & Armstrong, 1996, p. 61). The objective action of physicians in accordance with scientific law establishes a superior ontological standing for physician knowledge while relegating other ways or actions as subjective and thus less valuable. However, Dingwall and Allen (2001) argue that nursing as an occupation emerged "partly as a result of the technological changes in medicine that led doctors and their allies to rethink the role and organization of hospitals" (p. 68). Therefore, although the nursing profession attempts to distinguish itself from medicine, the profession shares many of the positivist views of their physician colleagues and on this account; nurses' work has been shaped by possibilities facilitated through the objectivist discourses of medical science. How nursing has taken up particular views will be explored more fully in chapter three.

Goodman (1995) discusses the phenomenon of "expert" and contends that the ideology of expertism has led us to rely on experts as authorities, based on their "specialized domain of knowledge" (p. 19). This ideology in health care positions the physician [expert] as the health care provider with the answers. The reliance on

physicians as experts contributes to the dramatic increase and domination of technological and scientific approaches to health care. The focus of health services situated in hospitals and focused on the delivery of types of services is inconsistent with the initial concern, that of the health and welfare of citizens.

Dividing practices

In 1947, the World Health Organization defined health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (Armstrong & Armstrong, 2003, p. 13). Although this definition has been articulated for fifty years, the emphasis in Canada has been on the delivery of health services to the sick. The focus on equitable access and affordable health care services has dominated the health landscape. Armstrong & Armstrong (1996) suggest that in order to re-form health care, the fundamental assumptions that the system is based upon must be challenged. They indicate that the current regionalization initiatives are built on assumptions that will serve to perpetuate the very system that is professed to need changing.

Foucault (1973) argues that the clinic or hospital was developed as the place where disease could be observed taking its natural course within the body. Disease was treated as a natural phenomenon, and patients only needed to be carefully observed and listened to for signs and symptoms, for their histories, spaces and courses to be described and defined. Central to the formation of a new order of knowledge is the abstraction of the patient as a social being, “in order to know the truth of the pathological fact, the doctor must abstract the patient” (p. 8). The concern for health is subsumed by the focus on disease and identifying normality. Foucault indicates that,

If the science of man appeared as an extension of the science of life, it is because it was medically, as well as biologically, based: by transference, importation, and, often, metaphor, the science of man no doubt used concepts formed by biologists; but the very subjects that it devoted itself to (man, his behaviour, his individual and social realisations) therefore opened up a field that was *divided up* [my emphasis] according to the principles of the normal and the pathological (p. 36).

The technology of division or “dividing up and objectification” of the patient by medicine is mirrored in nurses’ practice. LeBlanc (1997) demonstrates that nurses, like physicians, have also objectified patients. For example, the SOAP system of note taking includes subjective (S), objective (O), assessment (A) and, plan (P) information that abstract the client’s subjective experience. LeBlanc claims that although this might be an efficient way to capture information, “this subjective information is a bracketed piece of an individual response that the nurse uses to construct the narrative components of the nursing visit” (p. 259). LeBlanc points out in this example that the context of the individual is somehow put aside and signified as subjective as if it is possible to divide up an individual in such a manner. She cautions nurses to be aware of the labels and commensurate meanings that they construct about their patients in the name of objectivity and efficiency.

Technologies of division are further played out in the health care system in the manner in which services are divided up into types that tend to mirror medical specialities. For example, typically in hospitals there will be departments of surgery, medicine, emergency and so on. These dividing practices might also be taken as a form of governmentality. Each type of service is governed by many different types of activities that discipline the behaviour of health care providers and patients.

These dividing practices can be studied in terms of their governing impact: divisions [of systemic therapy and radiation] must maintain separateness for purposes of

sustaining arguments related to ‘expert knowledge’ but also must be amenable in certain ways to wider governing demands of the organization as well as the particular demands of specific patients seeking cancer treatment. The conduct of professional cancer treatment is then, a site of some contention as the competing demands of professionals, patients, and contemporary health care organizations make certain actions possible while severely limiting others. The next section draws our attention to these contentious debates and seeks to describe the particular form they have taken in Canada.

Health care as deficit management

The increase in hospitals did not meet the stated government mandate of providing necessary, affordable services. Throughout the 1950s, 1960s and 1970s the federal government and the provinces continued to negotiate each of their financial responsibilities and several pieces of legislation were passed in attempts to clarify respective responsibilities. ‘Affordability’ of health care became a theme that has dominated the health care scene since the early 1980s.

In response to a federal government concern regarding the escalating cost of care, a new funding arrangement was introduced in 1977. The 1977 funding formula paved the way for federal cutbacks. The new formula “moved away from a matching plan to an allocation based on past expenditures, growth in the overall economy, population, some provincial equalization payments to limit disparities, and a transfer of some taxation rights to the provinces” (Armstrong & Armstrong, 2003, p. 56). This move essentially capped cash transfer from the federal government and moved more financial responsibility to the provinces and territories.

The 1984 *Canada Health Act* enabled provinces to insure other health professionals and also outlined sanctions in the form of reduced transfer payments to provinces that allowed extra billing of physicians who charged user fees. This *Act* brought together the previous acts and reiterated the principle that Canadian citizens have the right to health care services without facing financial or other barriers. However, these beliefs were challenged by the provinces' increasing concern regarding costs and the priority of the federal government to manage the deficit.

According to Armstrong and Armstrong (2003), a new Canada Health and Social Transfer (CHST), which was a combination of the previous health and post-secondary budgets and the transfers for social assistance “cut billions of dollars each year from these programs beginning in 1996-7” (p. 57). They further maintain “the 1999 budget restored much of the money cut from health care in 1995, but by then considerable damage had been done to the public system” (p. 58).

The provinces were challenged in the early 1990s to re-examine fundamental health care assumptions, which apparently were driving the system costs. According to Church and Barker (1998), the themes emerging from a wide variety of Canadian health care reviews include: “*containing costs, increasing the efficiency, and enhancing the responsiveness and accountability [my emphasis] of the system through decentralized decision-making, and facilitating citizen participation*” (p. 469). Church and Barker contend that the high cost of health care spending was of concern to the provinces particularly as those expenditures have not been seen to necessarily improve the health status of health care users. They suggest that the emphasis on illness and hospitals, rather

than on prevention or health promotion, has contributed to a lack of progress in improving the health of Canadians.

The reduction in federal transfer payments of health dollars resulted in a wide variety of provincial cost-saving initiatives designed to make the health care system more efficient and effective. As the focus on affordability dominated the landscape, health care organizations sought strategies that were assumed to have been successful in the private business sector. This was framed by an effort to “increase efficiencies” and “contain costs.” Total quality management (TQM) or continuous quality improvement (CQI) initiatives became prevalent in the 1990s.

Efficiency – In the Name of Cost Containment

Totally quality management

The TQM movement, based on the experience of Japanese business, was seen to be applicable to health care as the techniques supposedly combined caring with cost savings, and also because providing quality care in teams was familiar to health care staff (Hoffmaster, 1998). Morgan (1997), utilizing the metaphor of organizations as brains, suggests that TQM requires not only a shift in thinking but also a *shift in power* [my emphasis]. One of the basic premises is that “different elements of the system take a lead in making various contributions” (p. 118). Taking the lead on an initiative may take place, but the “shift of power” does not necessarily follow. This notion of power perpetuates the simplistic view that power is somehow power over something that can be shifted as a result of some type of intervention. Rather, following Foucault, power produces knowledge and power-relations are everywhere. Therefore power is not seen to “shift” related to TQM activities, I argue, rather, that if new knowledge was seen to

emerge from these activities that power-relations would occur, but not because of a shift in “leadership” on some project. The bureaucratic, hierarchical nature of health care institutions does not change simply as the result of a different way of leading projects. Shifts in knowledge, practices, and commensurate power relations must take place in order for some sort of noticeable change to occur.

Armstrong & Armstrong (1996) suggest that the principles of TQM continue to perpetuate the medical model of care, as the focus is on re-engineering, through scientific methods, the parts of the system rather than the system as a whole. As a technology of division, TQM focuses on improving the parts of the system by measurement and control. This approach bears a strong resemblance to the scientific management strategies of Frederick Taylor (1911) and his assembly line approach to work.

In TQM, working groups are encouraged to make improvements to processes by breaking the process down into steps and making suggestions for change that will ultimately prove more efficient. Taylor would approve, as he promoted methodically observing work behaviour, in order to purify behaviour of what was considered extraneous or inefficient elements. Reconstituted in terms of fundamental units of movement, a machine-like regularity could be imposed on human action. Taylor held that the “substitution of science for the individual judgement of the workman cleanses work settings of traditional prejudices and personal idiosyncrasies” (Taylor, 1947, p. 114).

Ferguson (1984) describes the power in bureaucracies as “control of work through control of the technological aspects of production, through the design of machines, the direction and pacing of work, and the architecture of the workplace” (p. 89). Ferguson

suggests that bureaucracies seek to eliminate uncertainty to assure control. One of the goals of TQM is to improve processes by decreasing variation in labour practices. If variation is decreased, then control can be established. The use of measurement and controls by the workforce is seen by Armstrong & Armstrong (1996) to contradict the notion of workforce empowerment and innovation as, ultimately, success is marked by increased efficiency and, ultimately, the reduction of the workforce.

Hoffmaster (1998) contends that the most common mistake being made by health care leaders is in not recognizing the impact of the business language being used in TQM, i.e. referring to patients as customers. He states “language is not simply a tool but a shaper of ideas and values” (p. 38). Hoffmaster suggests that through the power of language the potential exists for health care to become viewed as a commodity. Prado (1992), following Foucault, emphasizes the need “to understand the structure of discourse that makes something count as knowledge” (p. 126). In the case of TQM, the discourse of contemporary health care reform has been driven by the language and rhetoric of deficit management, cost imperatives and the perceived need for increased efficiency in the system. There is very little, if any, language related to care or caring for the sick.

Dingwall and Allen (2001) argue that a customer approach to health care is incongruent with a bureaucratic health care system. Further, they suggest that in a market society comparing health care services to other customer services sets up the conditions whereby both patients and staff become dissatisfied as neither their individual or in the case of staff, professional needs are met. I argue, following Foucault’s understanding of governmentality, that TQM was set up as an activity that would affect the conduct of workers, not dissimilar to that of Taylorism. The delivery of particular forms of health

care has been amenable to this type of governing. For example, I have participated in TQM process improvement teams designed to make changes to operating room scheduling, wait list management, and streamlining patient admission procedures. All of these were intended to increase efficiencies by reducing the number of steps in each of the particular process under study.

Hoffmaster indicates that there are many supporters of TQM in health care, but the results have been inconsistent and that the system has not been transformed as the discourse would lead one to believe. In the broader health care sector, simultaneous with the growth of TQM in health care, a plethora of royal commissions and government task forces were asked to examine the health care system and recommend strategies that would both reduce costs and improve care for Canadians.

Re-forming practices

In British Columbia, the Royal Commission on Health Care (1991) claimed that many boards, agencies, and service providers contribute to the apparent inefficiency of the health care system. The lack of co-ordination of services made access difficult, and the duplication of services seemed obvious. The lack of citizen participation in health care decisions was identified as another factor contributing to the lack of responsiveness of the system to the changing needs of the population. A British Columbia review of community participation (1998) concluded that “decisions about health and social services are usually made by relatively few people, with little chance for participation by those whom the decisions affect” (p. 3). In other words, the priorities of the health care system were not necessarily those of the citizenry. Regionalization of health care

services was identified as a strategy to address the themes identified in various health care reviews.

According to the Canadian College of Health Services Executives' 1996-97 environmental scan, nine out of ten provinces embarked on various forms of regionalization to their health care services. Although regionalization initiatives are somewhat unique in each province, Church and Barker (1998) identify some common characteristics.

The first is the establishing of regional governance and management bodies that serve to centralize governance to "facilitate coordination and planning at the regional level" (p. 471). However, Frankish, Kwan, Ratner, Higgins & Larsen (1998) report that community participation in British Columbia had not improved following regionalization of health services. Citizens did not report increased involvement in health care decision-making.

The second characteristic is to move to providing health regions with global budgeting rather than targeted funding controlled by the Ministry of Health. Regional authorities, utilizing guidelines, would be free to disburse funds based on the needs of their population without interference from a central agency.

The third characteristic is the shift in focus from institutionally based care to community based care. The purpose is not only to reduce costs but also to provide services that are closer to the persons needing the services. The fourth characteristic is the recognition that outcomes must be measured, tracked and evaluated. The idea is to ensure accountability, and that the services being provided are making a difference to recipients. The fifth characteristic is the intention that, once regionalization has occurred,

there will be devolution of tasks now performed by government ministries of health. The belief is that the ministries would be involved in setting broad provincial health goals, but would not be responsible for funding.

The current discourse of regionalization promises solutions to what appear to be problems with the Canadian health care system. However, as Halpin (1970) indicates, “each new movement needs a new flag, a new slogan, or at minimum a new pennant” (p. 157). He described the tacit assumptions inherent in the “mythology of change” and they include,

1. that planned change can be engineered and engineered on a big scale and a long-range one;
2. that change can be effected quickly and indeed, dramatically;
3. that money will buy anything; and,
4. that noble intentions and hard work, especially when coupled with enough money, will achieve the results we desire (p. 175).

These assumptions bear a striking resemblance to the current beliefs fundamental to the implementation of regionalized health services across Canada. The question that remains is whether the discourse of regionalization is congruent with the concept of improving the health status of Canadians.

Organizational Change – A Case Study

Purpose

As discussed previously, many health care organizations in the 1990s faced with large deficits, and reduced funding, and perceiving burgeoning volumes of patients, undertook a variety of restructuring initiatives to position their organisations for the future. Similarly, the cancer organization in my study commissioned the services of a consulting firm and underwent a major re-engineering process in 1995/96 that was

intended to “develop alternate methods of organizing and leading [their] health care delivery system” (Cancer Agency, 1995, p. 8).ⁱⁱ

Referred to as a Cancer Care Assessment and Restructuring (CCAR) project, the main purpose was to “position the organisation to excel in its role as the provincial co-ordinator of comprehensive cancer care” (p. 4). The first part of the initiative entailed an extensive assessment or organisational review and was undertaken through September, October and November 1995.

Assessment

The methodology for the high level organisational assessment included; interviews, focus groups, data gathering, analysis of agency payroll and human resources data, examination of additional financial information, analysis of agency and Canadian Institute for Health Information (CIHI) data, review of patient care guidelines, policies, committee minutes and project reports, review of agency statistics, human resources profiles, scheduling systems, and equipment logs, physical tours of patient care areas at all the cancer clinics and a more thorough review of radiation therapy services and the ambulatory care units. At the end of this initial assessment, a report was presented to the executive group that highlighted issues that needed to be addressed before further work could commence. These issue areas were, organisational structure, mission clarity, clinical resource use, relationship of cancer clinics and others. Under the others, the role of the multidisciplinary teams and tumour site care teams were identified.

The report goes on to identify the key issues in each of these areas and opportunities and strategies for improvement. Although my study is focused on the

ⁱⁱ Names are fictitious to protect organizational identity.

nursing practice aspect of oncology care, it is important to understand the changes that were designed to impact the entire organization including nurses' practice within the context of the broader organization.

Process

Following the assessment, teams were put together to address the issues outlined in the initial report. There were six teams assembled. Each of the teams had a mandate, scope, and project work plan outlined. The scope of each team was refined as they progressed and areas of priority and overlap with other teams were identified. Team roles were explicated including the leader, secretary, facilitators and members. Typically the leader of each of the individual teams was also a member of the larger CCAR steering committee. The purpose of the cross membership was to ensure that the work of the six teams was aligned and that potential conflicts were identified and resolved before work progressed. For example, each of the teams identified the need for scheduling improvements and instead of each team working on how these improvements might occur, the issue was handed over to the Information Change team for them incorporate into their work plan.

The facilitators were all members of the consulting firm and their role was to advise on "redesign methodology and procedure, benchmarking and best practices technology and to assist the team leader in conducting meetings" (Patient Care Change Report, 1996, p. 3-3). There were twelve to twenty-two members on each of the teams. The members on each team were meant to be reflective of the work to be done by that team. For instance, the Information Change team included members from health records,

unit clerks, information systems, admitting and so on. Whereas the Information Analysis Change team membership was heavily weighted towards physicians and epidemiologists.

All of the teams had the same work plan in that they were expected to move through six phases in a fourteen-week period of time. These phases were; planning and initiation, current state assessment, visioning phase, design phase, and implementation planning. Depending on the team, members met either weekly or bi-weekly for three to six hours at a time and often there were sub-groups that met in-between the main meetings to work on the project. Each of the teams submitted a series of recommendations to the CCAR steering committee. The steering committee then prioritized the recommendations into a series of “re-design” opportunities and resources were committed to many projects. As my study is focused on oncology nursing care, I will focus on the Patient Care Change Team as the recommendations from this group advocated a change to the role of the nurse in the ambulatory care clinics.

Patient Care Change Team

The Patient Care Change Team met twice weekly from February 5 – May 10, 1996, except for one week in March. The meetings were approximately six hours in length. The team consisted of twenty-one members including, physicians, nurses, radiation therapists, nutritionists, social worker, pharmacists, and clerical/secretarial staff. The team leader was a radiation oncologist and there were two members from the consulting firm in the role of facilitators.

Mandate and scope

The mandate of the team was to,

- design processes for the efficient linkage and flow of patients through agency facilities;

- design a process for the development of clinical standards and guidelines; and,
- design a process to define how clinical standards and guidelines are translated through the care process into care algorithms and care maps (Patient Care Change Team, 1996, p. 3-1).

The team was charged with ensuring that the re-designed processes would provide patients with cost effective, accessible, compassionate, optimal and timely care. Cost imperatives were articulated in the objectives. They indicated that the team, while keeping in mind quality and best practices, were also expected to “eliminate waste and inefficiency in order to reach a stretch target set by the steering committee, of savings in the patient care processes of \$6M-\$9M over the next five years” (p. 3-2). Thus, there was a fiscal bottom line that was expected to be achieved through the re-design process.

Work plan

A detailed work plan outlined numerous activities undertaken by the team to reach their objectives. Phase one consisted of clarifying the work to be done [scope/mandate] and developing a preliminary vision that was mentioned previously. Phase two entailed an assessment of the current state. The assessment compared resources in the various clinics, patient care processes, and diagnostic services. Data was gathered from internal [to the organization] sources including previous reviews, reports and quality improvement initiatives. External sources of data appeared more difficult to come by, as much of the available data was either from the US [for profit] or not focused on ambulatory care. Team members made site visits to several oncology ambulatory clinics in provinces in Canada. In addition, clinical nutrition services were explored both in Canada and the US. Workload measurement data were available for radiation therapy and comparisons could be made between clinics and recommendations were made regarding staffing requirements. Based on the data collected, the team concluded that in

the area of ambulatory chemotherapy, the clinics were considered leaders in their field.

This appears to be based upon cost effectiveness of the chemotherapy operations.

Design phase

In the detailed design phase, the team began by outlining common themes that they wanted to underpin any of the changes that they would be suggest. These themes included the notion of collaborative teams of care providers; a primary oncology nurse (PON) as the primary and consistent contact for patients; access to information via computers; development of care paths; a new scheduling system that would be more efficient and decrease patient wait times; and the development of clear discharge procedures and information for patients and physicians. Although all of these themes impact patient care, I will focus on the design related to the collaborative team and the PON as they most directly impact the practice of oncology nursing in the ambulatory clinic settings.

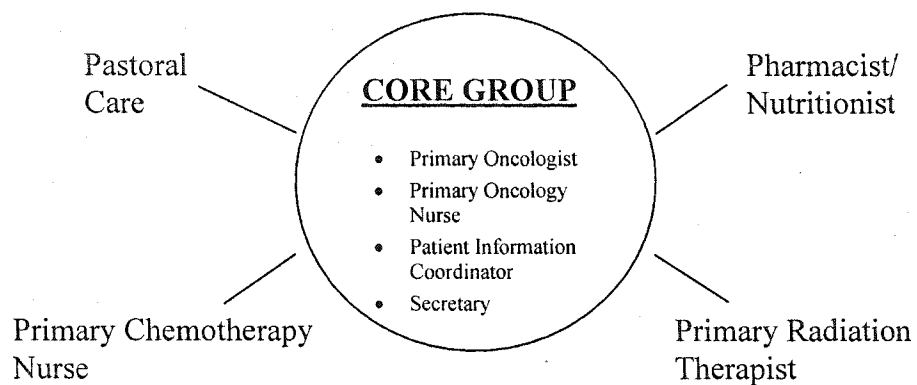
As a first step in identifying how care would be provided differently to patients, a model of care was articulated. This included provincial tumour groups; cancer centre [clinic] tumour site team and the patient care team. The provincial tumour groups were envisioned to have a provincial mandate to provide policies and clinical practice guidelines that would be taken up or implemented by the cancer centre site teams, and individualized for patients into care paths by the patient care teams. The goal was to provide standardised information for patients regarding treatment that would provide consistency and avoid duplication of work. The groups would have both internal [to the organization] and external professional membership comprising oncologists, surgeons, nurses and so on.

The cancer clinic tumour site teams were meant to be developed in each clinic with the mandate to implement the provincial policies and guidelines developed by the provincial group. There were several suggestions regarding how these teams could be put together, but it appears that the actual implementation was left up to the individual clinics.

Patient care team

The patient care team is described as having at a minimum, a primary oncologist [physician], PON, patient information coordinator and a secretary. Other caregivers were considered important, for instance social workers, but not integral to the experience of each patient in the clinic. Each of the roles above was explicated in detail with a caveat that they would evolve depending on the needs of a particular tumour group and patient population. The team report indicates that these three types of teams are congruent with the recommendation from the Organizational Linkage Team (OLT) that a programmatic funding model be implemented at the agency. I will focus on the changes suggested by the description of the patient care team, as these were intended to most directly affect the practice of nurses.

Figure 1. Patient Care Team Depiction



The report goes on to describe the roles of the core group. The model is described as a partnership of the primary oncologist and the PON covering the “same tumour sites and all the patients in that oncologist’s practice” (p. 8.1-12). The team apparently considered pairing the nurse according to tumour site, but that was determined by the change team to be less workable with too many nurse/doctor partnerships and would provide less consistent care for the patient in the patient care team. The original intention was to partner one PON with two oncologists according to the average number of patients that a physician sees in practice. Several situations are outlined that provide some flexibility in how this model of care could be enacted. For example, physician workload, nurses working part-time and anticipated and unanticipated absences had to be taken into consideration. One of the suggestions made was that there should be a floating PON to cover absences. In addition to explicating a new care model, the report outlines several design features that are also required for success.

Clinic organization and scheduling

The design features include clinic design, facilities, scheduling, and communications. In regards to clinic design and facilities, there is an attempt made to

recognize the need of patients for timely access to health professionals and also to organize clinic times and tests in a manner that reduces patient visits but also proves efficient for the organization. The report indicates that patient orientated clinics be considered a priority. In other words, the needs of patients should supersede the needs of the health care professionals.

The section on scheduling primarily deals with how the clinic visits should be organized to most efficiently utilize staff and also to decrease wait times for patients. This part of the report is also cross referenced with the work of the Patient Information Management Design team who were given the mandate to review, revise and re-design the scheduling system. The communication section refers to internal and external communications with patients and health care providers and includes the health record. Again the overlap with the Information team is discussed and several of the recommendations are handed over to that team to build into their design activities.

Barriers to success

Following an explication of the model, barriers to success were identified in the report. These include the necessity for,

- education of staff to the concept of collaborative practice;
- a change in the environment to facilitate a change in definition of the nurse and nurse/doctor relationship; and,
- a true evolution to collaborative and interdisciplinary care and so on (p. 8.2-1).

The report then describes the review and design changes in several other care areas including radiation therapy and chemotherapy. I will briefly touch on the discussion regarding chemotherapy, as there are implications for oncology nursing practice.

The goals in designing the chemotherapy process are stated, “to streamline and improve the services offered to patients” (p. 8.2-1). In terms of the role of the nurse, the PON is visualized as maintaining a relationship with the patient while he or she undergoes treatment, but the patient will receive treatment “from the appropriate treatment specialist” (p. 8.2-1). The idea was that the PON would see patients at their first visit and then maintain contact throughout their treatment regimes, even if she was not the nurse giving the chemotherapy treatment. The vast majority of the discussion about chemotherapy focuses on changes to the scheduling system and a cost analysis of how improved efficiencies might save money.

Following the design phase of the project, the team then developed an implementation outline that identified the priority activities in the first six months. In terms of the patient care model, these included the establishment of collaborative partnerships with oncologists. Further in-depth discussion regarding implementation and the changes to oncology nursing practice will form the basis of several other chapters.

Summary

Health care organisations in Canada share many of the features of large bureaucracies as care is shaped by the discourses of economics and managerialism. The discourses of health care in Canada since the Second World War have shaped the health care delivery systems that are in place today. Following Foucault, the proliferation of hospitals as tools for physicians and nurses to practice in the name of science, function to continue the disease model of health care. Efforts to re-form and re-engineer health care are often not seen as successful. However, in part, the assessment of success or failure depends on a particular concept of what these changes were meant to achieve. On the

basis of the earlier argument about technologies of division I suggest that there are many contradictions in the aims of the organizational change in this study.

Nursing practice is influenced by these organizational assumptions and discourses. Health care re-forms, the increasing economics of health care and the so-called crisis of caring are but a few that influence the nursing profession. The organisational change initiative that occurred at the cancer clinics in this study provides a case study of how one organization articulated a new way of providing care for oncology patients.

The Foucauldian concept of disciplinary oversight [surveillance] in the form of professional policies/procedures and processes serve to govern practices. Nurses both contribute and participate in actions and activities that mediate practice. Following Foucault (1977), discipline is a “productive power par excellence: it aims not only to constrain those over whom it is exercised, but also to enhance and make use of their capacities” (Hindess, 1996, p. 113). The mediation of practices by nurses and leaders are mechanisms of power, control, and self-control. The next chapter is concerned with exploring how oncology nursing has been conceptualized.

Chapter Three: In the Name of Cancer Nursing

The first fifteen years of the nineteenth century present the spectacle of an extraordinary movement of millions of men. Men leave their habitual pursuits; rush from one side of Europe to the other; plunder, slaughter one another, triumph and despair; and the whole current of life is transformed and presents a quickened activity, first moving at a growing speed, and then slowly slackening again. What was the cause of that activity, or from what laws did it arise asked the human intellect?

The historians, in reply to that inquiry, lay before us the sayings and doings of some dozens of men in one of the buildings of the city of Paris, summing up those doings and sayings by one word – revolution. Then they give us a detailed biography of Napoleon, and of certain persons favourably or hostilely disposed to him; talk of the influence of some of these persons upon others; and then say that this is it to which that activity is due, and these are its laws.

But the human intellect not only refused to believe in that explanation, but flatly declares that the method of explanation is not a correct one because in this explanation a smaller phenomenon is taken as cause of a greater phenomenon. The sum of men's individual wills produced both the revolution and Napoleon; and only the sum of those wills endured them and then destroyed them.

For the investigation of the laws of history, we must completely change the subject of observations, must let kings and ministers and generals alone, and study the *infinitesimal elements by which masses are led* [my emphasis].

War and Peace, Leo Tolstoy
Modern Library Edition.

Introduction

There are similarities between the study of history described above by Tolstoy and the study of nursing practice. For example, much has been written on the broad subject of leadership and since 1986 over 600 articles relating to nursing leadership have been indexed in the Cumulative Index of Nursing and Allied Health Literature (CINAHL). Only a small number of these, however, identify the discourses inherent in nursing leadership practices and their relationship to [nursing] practices in the clinical settings. In order for nurse leaders to understand how it is that they might positively

influence practice, it is necessary to do as Tolstoy suggested above, and completely change the subject of observation and “let kings and ministers and generals [leaders] alone” and instead “study the infinitesimal elements [influences] by which the masses [nurses] are led”. This should not be construed as ignoring nursing leadership, but rather I take the position that studying at the level of the “masses” rather than the “generals” will provide both nurses and leaders new understandings about how practice is enacted and the things that influence that enactment.

As previously discussed in Chapter Two, health care organizations in Canada have been affected by governmental policies that, over time shifted the responsibility for social issues from the state to the individual. The impact on health care delivery following an economic and business agenda has, in turn, influenced the way in which nursing care is delivered. One focus of the restructuring at the cancer clinics was to change the service delivery model and the way in which nurses care for oncology patients. In order to ascertain how this initiative maintained or changed oncology nursing practice, it is necessary to understand how oncology practice has come to be understood outside of this particular restructuring. This chapter explores how oncology nursing practice has been conceptualized, and it reveals the competing discourses that nurses somehow manage to practice through. Following Foucault and Giddens, I suggest that these conceptualizations only partially explain how it is that nurses enact their practice and that a study of that practice is required to reveal how these contradictions are dealt with in the day-to-day. This chapter explores how nursing practice, and in particular, oncology nursing practice, has come to be understood and the discourses and commensurate authority claims that have influenced these understandings.

Portrayal of Practice

Practice as problem solving

Nursing practice is studied and portrayed in the nursing literature and in nursing textbooks as what nurses do and how they do it (Heron, 1987; Hiraki, 1992; Long, Phipps & Cassmeyer, 1993; Potter & Perry, 1997; Wong & Perry, 1998). Nurses are taught during their initial formal educational programs and throughout their careers how to apply certain kinds of knowledge in order to care for patients. In the textbook, Nursing Care of Infants and Children, Whalley & Wong (1983) describe in 40 chapters the goals of care for various childhood disease/disorders and the nursing responsibilities. For example, in chapter thirteen the nursing care for a child with non-organic failure to thrive is described. One goal of the nursing care for these children is “to introduce a positive feeding environment” (p. 467) and the nursing responsibilities are stated,

Assign one nurse for feeding; maintain calm, even temperament, be persistent; provide a quiet environment; hold young child for feeding; establish a structured routine and follow it consistently (p. 467).

Nursing practice in this example is depicted as a series of actions that can be applied in a practice setting.

The *how to* approach to practice is further illustrated in an article by Fishwick (1995) that describes how nurses should respond to women who are victims of domestic violence. Fishwick outlines a series of assessment steps and accompanying questions that nurses should undertake in order to identify and assist patients in abusive situations. This depiction of nursing practice includes identification of an issue or problem and, then, a prescription of how that problem should be addressed or followed up in the acute care setting. This approach to practice somewhat typifies how it is that nurses are taught

to practice. In spite of nurses having apparently been taught how to deal with domestic violence, a 1999 report commissioned by the British Columbia Ministry of Health indicates that the “health care system responses [to patients in abusive situations] have been characterized by a lack of recognition of abuse and the prevalence of negative attitudes and responses” (p. 13).

In this example, why is it that the positive patient outcomes that are meant to result from the application of knowledge about abuse recognition are not forthcoming? To answer this question, typically, efforts would be directed towards identifying the barriers to implementing the aforementioned educational program and assessment procedures regarding the response to women who are victims of domestic violence. Once the barriers are identified, the nurses would be encouraged to continue with their assessment efforts, perhaps with some additional education, all the while assuming that position that positive outcomes will occur by following these procedures. This study challenges the assumption that the application of knowledge in a practice setting is somehow an isolated action that is not subject to influences particular to that setting.

A nursing research emphasis on commonality of nursing practice settings and generality of knowledge to support practice in those settings has contributed to the view that nursing practice proceeds in a logical and predictable manner across a wide range of contexts (Schlotfeldt, 1989). The notion of predictability of practice suggests that there is *one best* way to practice and negates the features of individual patients, organizations and practice settings.

The nursing literature that sets up the assumption that nursing practice proceeds in a predictable manner, is problematic as it limits the possibility of influence (Hiraki,

1992). These academic sources that claim to support nursing practice, in fact fail to appreciate that nurses are active participants in constructing their practice. These sources further negate that the context of the practice settings and the organizations they reside in influence how practice proceeds, and indeed create conditions for practising quite differently in different settings. It is interesting that the recognition of the potential for difference and diversity in nursing practice are largely absent in the nursing literature, particularly given that attention has been given to the notions of diversity within patient populations. Within the context of the Tolstoy quotation, I suggest that it is puzzling indeed that there is little debate about the diversity of nursing practice given the complexity and multiple contexts in which nurses enact their practice.

It is not unreasonable to suggest that leaders who take up this *predictive* view of nursing practice may be inclined to also expect that organizational changes such as those initiated by the cancer clinics would result in changes to practice [my emphasis]. Particularly if, as Copnell (1998) suggests, leaders also engage in an instrumental discourse of change that is context free and is understood as a series of tasks. It follows, using this frame, that applying tasks [process] to predictable practice will result in practice changes. I suggest that practice is more complex than that depicted in the literature and if leaders want to see changes in practice that will result in positive patient outcomes, they first must have an understanding of practice that goes beyond the usual view of tasks that nurses perform. This necessitates exploring some of the “infinitesimal elements” that guide nurses’ practice.

Experiential practice

From the mid 1980s onwards, nurses' fascination with the work of Patricia Benner (1984) can be read as an attempt to move away from the predictive approach to nursing practice. In the foreword to Benner's book, M. Aydelotte, the retired executive director of the American Nurses Association, describes Benner's work as:

A lucid, colorful description of nursing practice as tendered by expert nurses [and] we learn what expert nurses do in specific patient situations, how beginners and experts *do it differently* [and] the value of this document lies in the understanding it gives us about the mystery of expert nursing practice (p. v) [my emphasis].

Following Benner, the problem of diversity in practice is reduced to categories (novice to expert) with the implication being that nurses need to move into the expert category and then they will "do it differently". This categorization of nurses implies homogeneity amongst nurses in each category. Benner's research was based on dialogue with nurses and included "only patient care situations where the nurse made a positive difference in the patient's outcome" (p. xx). Accounting for nursing practice through the subjective narrative experience of nurses was viewed as a positive alternative to the notion that practice can be standardized by rules, procedures and regulations (p. vi).

Taking the subjective narrative accounts about practice to represent everyday practice is problematic. It is simplistic to suggest that nurses' stories can be construed to be the totality of nursing practice. Giddens (1987) indicates that ordinary language is open in an important sense. Most of the words and phrases used in everyday talk do not have precise lexical definition. As Wittgenstein showed, ordinary language is not thereby necessarily vague or indefinite. What gives ordinary language its precision is its *use in context*. "Settings of talk are used by participants to define the nature of what is said" (Giddens, 1987 p. 104). Nurses actively participate in constructing their practice and

their talk of practice encompasses multiple contexts, including organizational, clinical and social. Giddens contends, “[talk] is carried on and organized within practical contexts of action” (p. 104). Therefore, an exploration of nursing practice necessitates more than an examination of narratives. It requires a deeper examination of practice that goes beyond ‘talk’ and includes observation of practice in the making, in order to extend the examination to its “use in context.”

Context

Following Giddens (1977, 1984, 1987), I advance the argument that nursing practice is produced in relation to the context of its enactment. Giddens indicates that context includes “the physical environment of interaction but is not something merely in which interaction occurs” (p. 71). He describes context further, in relation to time/space and regionalization. Giddens refers to locales as “the use of space to provide the settings of interaction, the settings of interaction in turn being essential to specifying its contextuality” (p. 118). Within locales, regions or spaces are zoned differently in relation to time and space. Giddens uses the example of a house with different floors and rooms that are utilized at differing times of the day/night and describes how the meanings of the various zones/regions contribute to contextualizing the meanings of interactions.

Giddens (1987) also discusses the contextuality of action. He describes human social life as “relations between individuals moving in time-space, linking both action and context, and differing contexts with one another” (p. 99). Regions refer not merely to space, but also to social relationships. Within nursing practice there are regions of distinctive and different interactions between nurses/nurses, nurses/physicians, nurses/patients, and so on. Giddens offers an alternative to the view of practice as a predictable

series of tasks. His conceptualization suggests that actions [nursing practice] are situated in relation to others' actions; in this case those of other health care professionals and patients. In order to contextualize the oncology nursing practice it is necessary to examine those practices in the multiple contexts of their "social relationships" including the organizational restructuring [change] initiative. This approach is different than that typically undertaken by nursing to explicate practice changes as a result of organizational changes.

In a study of change in clinical nursing practice, Copnell (1998) indicates that clinical practice is under-researched from the perspective of the nurses themselves and in relation to their practice settings. Copnell argues that disregarding the context where changes in practice take place sets up a situation whereby nurses are disadvantaged by their limited understanding of change. The prevalent understandings of change, shaped by organizational and administrative discourses, and modified by scientism, serve to marginalize nursing practice as it silences their views and experiences. Further, Copnell points out that in ignoring the context of clinical changes, nurses are viewed as either "targets who are at best irrational, and at worst, bad" [if clinical change is not successful] (p. 8). Using a post-structuralist approach to inquiry can offer different understandings of clinical practice that take into account both the understandings of the work from the nurses' point of view, and the context in which practice occurs (Copnell, 1998; Manias & Street, 2000; Rudge, 1996).

Conceptualizing environment

Contrasting Gidden's and Copnell's understanding of context, is the concept of environment in the nursing literature. According to Kleffel (1991) "the environment has

been a major concept in the domain of nursing knowledge since the time of Florence Nightingale, who clearly articulated what the nurse must consider to optimize the physical environment of the ill person so that healing could take place” (p. 149). A search of the nursing literature by Kleffel reveals articles where environment was considered either from the nurse’s or the patient’s perspective and only one study addressed the social, economic and political contexts of the environment. Kleffel (1991) suggests that environment, as a major concept of nursing, is limited. She indicates that the prevailing view of environment needs to undergo a change in order to keep pace with wider views regarding the impacts of social, political, economic and cultural conditions on the environment and in turn on the care and well being of patients/families.

Roy (1995) challenges the professions’ traditionally held perspective of the phenomena of environment, exploring the concept from four different interpretations. Firstly, she cites Rawnsley’s (1990) use of metaphors of the nurse patient relationship as a context for viewing environment as mediating presence. Roy goes on to explain that with each nursing action there is a patient context. Secondly, Roy explicates that, from a communicative [use of language] and institutional environmental context that nurses may be separated from those in need of their services. Thirdly, Roy explores environment as a ‘social’ position in an open field and suggests that nurses may be influenced by the institutional settings that they work in and where they are positioned subordinate to medicine. Finally, Roy describes a view of environment that takes into consideration how variables change and effect interventions (p. 82). Roy illustrates this point by suggesting that nurses who care for families with chronic health problems take into consideration differing family environments when they plan their interventions related to

parent/child interactions. Roy further suggests that there is a need for nurse scholars to develop new terminology that captures new perspectives of environment and that takes into consideration a broader view of this phenomenon.

The narrow conceptualization of environment held by nurse scholars contributes to the de-contextualized portrayal of nursing practice in the literature. New understandings regarding nursing practice will only come with new views of traditionally held beliefs regarding concepts such as environment, but the aim of such study must be made explicit. For example, Kleffel (1991) proposes that as “nurses practice in new settings they eventually, after more thinking, will arrive at a consensus on a new environmental paradigm” (p. 157). Unfortunately, the goal of consensus of opinion on nursing concepts may well be precisely what has contributed to our already narrow perspective regarding environment. To trade one narrow definition for another, does not contribute to an expanded view of how it is that nursing practice proceeds in the context of a practice setting, nor does it contribute to the development of new understandings.

Consensus

The nursing profession has endeavoured to establish consensus regarding the link between knowledge and theory, and recognition as a profession (Gortner, 1980; Kenney, 1996; Munhall, 1982). In a description of the Actor-Network theoretical approach, Munro (1999) indicates that although “much conduct is very likely sedimented and routinized, its courses are never fixed” (p. 431). It is therefore, somewhat simplistic to suggest that nursing practice is fixed and determined by a consensus of theoretical premises.

In a discussion of deconstruction, pragmatism, and democracy, Mouffe (1996) indicates that Derrida's approach to political decisions is to expose the notion of 'undecidability'. This concept entails the belief that with every decision taken, there are those that benefit and those that do not. "Consensus requires a temporary hegemony that entails some form of exclusion" (p. 10). When nurses describe their practice in the language of a particular theoretical model, or care delivery system, they in effect exclude other accounts of their practice. This type of exclusion silences not only the accounts of other health care professionals and leaders, but also the accounts of patients as recipients of that practice. Mouffe argues that consensus in practice is impossible as power and antagonism are integral to actions, and that practice is action. However, the ambition of developing consensus of opinion is prevalent in oncology nursing and one way it is manifested is in the movement towards developing standards of care to guide nursing practice.

Framing Oncology Nursing Practice

Prescriptive practice - standardization

The goal of consensus is problematic as much for what it includes as what it excludes. From a professional perspective, nursing practice has often been portrayed as predictable and ordered. Nursing actions/interventions and responsibilities are often said to be based on research and "the consensus of recognized experts" (Stetler, Brunell, Giuliano, Morsi, Prince & Newell-Stokes, 1998, p. 45). Nurse scholars, in attempting to reach consensus on knowledges unique to nursing, also set up the conditions whereby other knowledges are excluded. Professional organizations have followed the lead of the academics and have also engaged in identifying unique nursing knowledges that are

necessary to care for certain populations. The development of standards by various nursing professional associations has been one strategy to reach consensus regarding preparation of professionals and the care they provide to patients.

The Canadian Association of Nurses in Oncology/Association Canadienne des Infirmières en Oncologie (CANO) is a national nursing interest group dedicated to the provision of quality nursing care for persons affected by cancer (CANO, 1995). As part of their mandate, the association developed an array of standards for practice, patient and public education, oncology nursing education and administration of chemotherapy. These standards were developed in and validated by nurses across Canada in what is described [as] “a collaborative effort by nurses from a variety of settings” (p. 1).

Nursing standards

Oncology nurses claim to practice according to standards developed by experts in the field. A critical reading of the standards for oncology nursing education reveals an approach to oncology education that sets up conditions whereby the knowledge gained by practitioners may well be prescriptive and somewhat narrow. For example, as part of the educational standards, the educational curriculum must reflect the CANO standards; the faculty must demonstrate application of the CANO standards and the graduates must participate in patient/public education according to the CANO standards. This approach to educating nurses presupposes that practice proceeds in a predictable manner and that nurses can be taught according to a set of standards that have been agreed to by experts in the field of oncology nursing. Organizations such as CANO arose to provide the structure and rules of practice that are articulated in the language of standards of practice.

As previously noted, CANO has developed a number of standards for nursing practice, nursing education, oncology patient and public education and administration of chemotherapy. The intention of these standards is, in part, to “describe the practice of oncology nursing [and] make clear what the unique contribution of nursing is” (CANO, 1995, p. 5). The focus on articulating the unique contribution of nursing arises from the perceived need of nurses to be considered as professionals, with a unique body of knowledge similar to other professions. The goal of professional recognition by academic nurses led to the belief that consensus regarding nursing knowledge was essential. The CANO standards set up conditions upon which oncology nurses are meant to frame their practice. These conditions include the use of a conceptual framework, the use of the nursing process, establishing a collaborative relationship with patients-families and fulfilment of professional responsibilities.

The influence of academia is apparent in the CANO’s requirement for utilization of a nursing conceptual model. The adoption of a theoretical model as a standard is intended to establish oncology nursing practice as both academically and scientifically respectable as per the dominant medical, scientific perspective. CANO (1995) utilizes the nursing process as a “systematic approach to the delivery of nursing care” (p. 7). The process consists of five steps that are consistent with traditional, positivist scientific research methods, i.e., data collection, data analysis, planning interventions, intervene, and evaluate interventions. These two standards perpetuate the unique knowledge of scientific medicine rather than highlighting the knowledge that nurses require in order to care for patients in their practice. Further, as a description of nursing practice, one is left wondering, how it is that patients benefit from the standard that suggests that oncology

nurses should be able “[to] express the specific goals of oncology nursing to other team members” (p. 7). This could be construed as professionally self-serving rather than as beneficial to patient care.

The third and fourth CANO standards refer to establishing a relationship with patients/families and fulfilling professional responsibilities. These standards describe what it is that nurses do rather than the knowledge that they bring to their practice. The distinction between doing and knowing is, in part, what Benner (1984) suggested by her position that practice can precede theory. In contrast to this position, I argue that oncology nurses have knowledge about the local specific circumstances where they practice and that they construct spaces for their practice contingent upon these local circumstances. They utilize both academic knowledge and local knowledge to care for their patients. The question that this prompts is which knowledges are in the foreground and which are in the background? Additionally, how do these knowledges relate to what goes on in the name of cancer nursing?

This is not to say that “standards of care” do not have their place, but, that the current conceptualization of standards must be understood in the context of the variety of practices of nurses, the populations they serve, and recognition that knowledges are excluded in these attempts at standardizing care. Standards must be critically examined for what types of practices are endorsed and what types or views of knowledge are included in their development. For example, CANO Education Standard V states, “Graduates of the nursing education programs with an oncology focus will demonstrate an understanding of *the* [my emphasis] scientific knowledge base of oncology nursing” (p. 10). This standard might lead one to believe that there is but *one* scientific knowledge

to base care on, rather than there is an array of knowledges that nurses draw upon to care for patients.

Mouffe (1996) argues that the demand set up by such standards requires a temporary hegemony. In order to achieve that hegemony forms of exclusion result no matter how temporary or fleeting. In this example, space is not created for other than the positivist view of “scientific knowledge.” By seemingly negating that there are varieties of scientific knowledge, this particular education standard is arguably a very narrow guide for oncology nurses. The value of standards and standardization of care needs to be weighed against what is excluded in their development and how this exclusion might impact patient care. For instance, it is contradictory to guide oncology practice by the use of prescriptive standards and at the same time hold out the importance of individualizing care to patients. As previously stated, somehow nurses play out these competing interests and this study attempts to explicate how they come to do so in the face of such contradictory guidance.

Building on the concept of standardization, oncology nurses are also pressured with a consensus approach to practice that is prevalent within all of the health care professions as they attempt to develop care guidelines or care maps for particular patient groups based on evidence.

Standardization – in the name of science

Nursing actions, interventions, and responsibilities are often said to be based on research and the “consensus of recognized experts” (Stetler et al., 1998, p. 45). Perhaps the most well known example of this is the Cochrane Collaboration that brought together individuals from nine countries with the express purpose of critically examining the

evidence of particular diseases and conditions and rendering a consensus opinion (Chalmers, 1993). The consensus opinion based on the synthesis of available research is then meant to be used as a guide for clinical practice (Barnes, 2000; Stokes, 1998). So-called evidence based practice is yet another way to frame or guide oncology practice.

Estabrooks (1998) examines the origins and consequences of evidence-based nursing (EBN), and cautions the nursing profession to “embrace but not be bewitched by EBN” (p. 31). Estabrooks points out that given the complexity and context of practice settings, clinicians, and patients that it may be simplistic to suggest that there is one best way to practice. The consensus approach to care is reinforced in oncology nursing in the restructuring initiative with the aim that called for the development of “care paths to enhance the delivery of evidence based treatment policies” (Patient Care Change Team Report, 1996, p. 2-3).

Nurses in practice are expected to be involved in activities, for example the development of nursing policies and procedures designed to ensure that practice is based on research. The conceptualization of EBN is that this results in improvements to nursing practice, which in turn is meant to benefit patients. The premise of these types of activities is that practice can be influenced or indeed changed by the application of some type of intervention, rather than the belief that practice is contextual and emerges through a range of organizational and professional discourses.

Stetler et al. (1998) describes a process their organization undertook to “institutionalize evidence as a routine part of nursing practice” (p. 45). The authors indicate that they desired an enhancement in the use of research in practice. They do not indicate what the concerns or patient care needs were that were not being met by the

apparent lack of EBN or the potential positive patient outcomes that they hoped to achieve. This group adopted the following summary definition,

Evidence-based nursing de-emphasizes ritual, *isolated unsystematic clinical experiences*, [my emphasis] ungrounded opinions, and tradition as a basis for nursing practices and stresses instead the use of research findings and as appropriate, quality improvement data, other operational and evaluation data, the consensus or recognized experts and affirmed experience to substantiate practice (p. 49).

Throughout their discussion of how to imbed research in practice, the absence of patients' perspectives or practising nurses' perspectives at either the pre-EBN or the post- EBN is, in my view, problematic. The assumption that is being made is that nursing practice can be modified by the application of, in this case, EBN without taking into consideration the nurses in the practice setting. In their conclusion, the authors indicate that the approach they took, resulted in an enhancement of critical thinking, a more reasoned reliance on research findings, and a increased recognition of the value of the use of research as a process on a day-to-day basis (p. 52). I am unclear how it is that these outcomes have come to change nursing practice in the day-to-day. This type of nursing leadership approach, now linked with research practices, to improving practice perpetuates the notion that practice changes based on an application of an intervention rather than being constructed by the nurses themselves.

There is no mention of positive patient outcomes as a result of the adoption of EBN. How is it that these nurse leaders know that a positive change has occurred? If a change has occurred how would nurse leaders know that it was as a consequence of the adoption of EBN? Conversely, are positive outcomes attributed to nurses, de facto positive for patients? Is it reasonable to equate satisfied nurses with satisfied patients? The outcomes explicated in this article typify how it is that nurse leaders utilize indirect

measures such as these to leap to the conclusion that patients will be positively impacted. I find this approach to be problematic, as the perspectives of patients in regards to nursing practice are silent.

As previously discussed, Estabrooks (1998) suggests that taking up evidence based practice (EBP) without critically exploring the potential benefits to patients is problematic. She suggests that there are different ways of utilizing research in practice, for example, directly in the form of procedures and indirectly as informing practice from a conceptual perspective (Estabrooks, 1997). Further, she indicates that the influences on practice are broader than those articulated in the current language being used to explicate evidence based practice. Johnson and Ratner (1997) concur and question whether “good science is enough for good [nursing] practice” (p. 9). If nursing practice is taken to be more than that which is accounted for by the narratives of nurses and administrative leaders then the notion of influencing practice by administrative strategies and approaches is problematized. Rather, those nurses who practice, and those who are recipients of practice, the patients and families, and those who influence practice, the leaders and institutions, constitute a form of practice in and of themselves.

Standardization is but one discourse that claims an authoritative framework to guide the development of the specialty practice of oncology nursing. In addition to the standardized prescriptive frame, oncology nurses are faced with other competing discourses including, recognition of predictable improvements towards expert practice, a desire to be inclusive in terms of patient experiences and a care delivery model that taken together are somehow meant to guide practice. However, taken together they also are

inherently contradictory. I will now go on to discuss how each of these conceptual frameworks are meant to guide practice and the contradictions that arise.

Specialization: Benner

The nursing profession, in attempting to develop a unique body of knowledge, similar to that of other professions, embraced the notion of expert through the work of Patricia Benner, a well-known nurse researcher, who rose to prominence in the mid 1980s. Benner's work was taken up by many in the profession as, according to Cash, (1995) the "attraction of her work is that she moved the emphasis towards the clinical practitioner and clinical practice and away from formalisms such as nursing models" (p. 527).

According to Mitre, Alexander & Keller (1998), Benner's research is influenced by the work of Heidegger and his phenomenological description of "person as a self-interpreting being who is defined by concerns, practices and life experiences" (p. 159). Benner (1984) utilized Polanyi's concept of practical knowledge to highlight 'knowing' that occurs when one is involved in a situation. Benner discusses, as well, the work of Gadamer in explicating the concept of experience in relation to knowledge acquisition. Benner's theory is further informed by the work of Hubert and Stuart Dreyfus who developed a model of skill acquisition. The model is situational and describes five levels of skill acquisition and development. The model posits that in movement through the levels of skill acquisition, changes in performance occur. The Dreyfus model explicates the "know-how that is acquired through experience" (p. 3). For example, the Dreyfus's studied how pilots come to acquire skills. Through their research, the Dreyfus's postulated, "with experience and mastery, the skill is transformed (p. 38). Expert pilots

were able to fly their planes, not by paying attention to the rules and guidelines that they used as beginners but by deviating from the rules and utilizing their experience.

Benner draws parallels between the Dreyfus model and Heidegger's premise that persons contribute to their own understanding of the world. Benner utilized the work of Polanyi to describe the difference between "knowing how and knowing that" (Benner, 1984, p. 2). This distinction of knowing provides the basis for Benner's contention that practical knowledge can precede theoretical knowledge. In other words, I may know how to do something but I don't know that the thing I am doing is right. The idea of right is that which is defined or endorsed by the profession or might work for the patient. However, if the knowledge informing nursing practice is contingent, drawing upon the context of their practice setting and all that entails, then the rightness of knowing may be contingent on what nurses in practice hold to be right.

Benner's emphasis on the value of *doing* is appealing to practising nurses. For many, it offers an alternative to the discourse of nursing theories that are difficult to understand and to some do not appear to have any relevance in the practice setting. Nurses construct their practice in a way that makes sense to them, in their particular setting at any particular time and Benner's work made sense to them in a doing sense. It is interesting to note that Benner's work focused on the nurses' experiences in practice and is silent regarding the patients' experiences.

In attempting to articulate the complexity of nursing practice, Benner's work became scripted in the words of experts and experience. She coined the phrase "from novice to expert" that has been taken up by many nurses to describe the particular area of practice that they engage in. The concern with this approach is that the patient's

perspective does not seem to be taken into consideration in relation to any particular nurse's expertise.

Benner's work created a new way of understanding and articulating practice. Benner's research indicates that expert nurses acquire knowledge through experience that provides them with an "intuitive grasp of situations" (1984, p. 32). The notion of expert knowledge is appealing, as, it gives the appearance of valuing the work and experience of practising nurses in a way that nurse scholars in developing nursing theories/model were not able to achieve.

However, Benner's claims regarding experience are problematic. In privileging the stories of nurses, she has taken them to be practice, as if practice occurs in the telling and that practice and knowledge can be fully represented by narratives. The idea that nurses' descriptions of how they practice are somehow the totality of practice is simplistic and exclusive of patients' understandings of the experience of being nursed. Benner positions the discourse of these stories as everyday practice.

Benner critiqued

Methodologically, Cash (1995) in a critique of Benner's work, argues that by ignoring the influence of power on nursing epistemology, Benner "does not raise the status of nurses' knowledge claims, but rather fossilizes a nursing practice distorted by the unequal power relations with competing epistemologies such as medicine" (p. 534). Knowledge and power are reciprocal, each producing the other; they are not separable (Foucault, 1972, 1976). Power-relations are apparent in all social interactions and relationships and therefore frame and shape the way in which nursing practice is

constructed and understood. An examination of nursing practice necessitates an examination of the power-relations inherent in that practice.

Purkis, (1994) challenges the philosophical underpinnings of Benner's work. Purkis maintains that Benner is inconsistent in her concept of experience as although Benner maintains that it is not associated with time, she goes on to explicate linear time lines for each of the five sequential stages of knowledge acquisition. In spite of these critiques, Benner's work continues to be embraced and the concept of a predictable movement towards expert practice goes virtually unchallenged.

Oncology nurses are one group of self-identified and professionally recognised speciality nurses. The oncology nursing association, CANO has taken up the discourse of experience and expert and have embedded these in the language used to explicate oncology practice. Examination of the documentation of CANO regarding oncology nursing practice reveals discourses of expert and specialist, "oncology nurses require broad knowledge base in nursing and a specialized knowledge [and] standards allow for excellence in the specialty practice [and] base their practice on a unique body of knowledge [and] a specialized body of knowledge and skills is basic" (CANO, 1995, p. 1, 2 & 3). The phenomenon of specialization as it is used by the nursing profession and oncology nurses in particular, represents an attempt to create a space within which to practice within the dominant patriarchal health care system. It is somewhat ironic that nursing, in a quest for professional recognition, has created a career structure that is remarkably similar to the medical hierarchy, i.e., through the elaboration of speciality practices that mirror medical specialties.

There are also parallels between the knowledge that the medical profession claim as guiding their practice and that of nursing. In the case of oncology nursing, their expert knowledge must compete with that of medicine who also self-identify as oncology specialists. The question that is worth exploring is what are the similarities and differences in the knowledges that each of these professions espouses to use to guide their practice? Further, which knowledges are excluded in the quest for “specialized unique knowledge.

Mouffe (1996) indicates,

A democratic approach which, thanks to the insights of deconstruction, is able to acknowledge the real nature of its frontiers and recognizes the forms of exclusion that they embody, instead of trying to disguise them under the veil of rationality or morality, can help us fight the dangers of complacency (p. 10).

Following Mouffe, framing oncology nursing practice as expert practice in such a manner operates to exclude other possibilities for examining and explaining practice. In particular, the view of speciality practice positions these nurses in the role of expert. How is it that space is then created for patients, who indeed one might argue are actually experts in their own health and illness process?

Benner’s concept that experts acquire knowledge through their experience and draw upon “an intuitive grasp of situations” is contradictory to the view of standardization and EBN. I am unable to reconcile how nurse’s intuition finds a space within a prescriptive frame for practice. EBN negates evidence [knowledge] that is described to be “isolated unsystematic clinical experience.” How then does the experience of so-called experts find a place in EBN? Is it possible to have expert nurses who practice outside of ‘scientific’ evidence? These are only two of the contradictions that nurses face as they attempt to follow those frameworks that have set up authoritative

claims to guide practice. In addition to the view of themselves as experts, utilizing standards of care that may or may take the form of care maps or guidelines, nurses are further guided in how they do assessments and documentation by using the theoretical framework of Virginia Henderson. This adds yet another dimension to the already multiple 'guides or frames' that oncology nurses are meant to take up to guide their practice.

Individualized practice – Henderson

Virginia Henderson was a well know nursing theorist who in her more than 60-year career is considered to have made an enormous contribution to the profession. Henderson was a prolific scholar and produced literally hundreds of articles, books and commentaries. Henderson (1966) states,

The unique function of the nurse is to *assist* [my emphasis] the individual, sick or well, in the performance of those activities contributing to health or its recovery (or peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge to do this in a such a way to help him gain independence as rapidly as possible (p. 7).

Henderson focused on the physiological and psychological needs of patients and identified fourteen basic needs that all patients have in common. Although Henderson suggests that there are common needs, her work was also premised on the belief that no two persons are alike. Nurses were encouraged to view each patient as an individual. Henderson put forth that the nurse's role was to "assist" the patient reach their optimum health, or recovery from disease, or good death. The "patient's meaning" of health, recovery, and good death was the guide that the nurse was to follow. It was not up to the nurse to interpret for the patient for example, what might constitute good health. Henderson conceptualized the primacy of the patient's interpretation of their situation

and positioned the nurse to assess the patient in an attempt to identify these interpretations and work with the patient to meet their goals.

Henderson viewed that nurses were part of a team whose members, while having unique roles and functions, also overlapped in some areas. Utilizing wedges on a pie to demonstrate each health team member's role and the patient's role in a particular health encounter, Henderson suggested that eventually, if recovery was the goal, that the patient would eventually have the largest wedge in the pie. As a forward thinker, Henderson did not imagine that her definitions would stand for all time. Rather, she indicates "nursing must not exist in a vacuum, nurses must grow and learn to meet the new health needs of the public as we encounter them" (p. 104).

As a guide to practice, Henderson's suggested approach to assessing a patient is very similar to the problem solving approach of the nursing process. What is different however is the emphasis on what the patient thinks his/her goal of care should be. Also, Henderson did not suggest that this was the only way to interpret the role of the nurse. Rather, she states,

My interpretation of the nurse's role is the synthesis of many influences, some positive and some negative...I should first make it clear that I don't expect everyone to agree with me. Rather I would urge every nurse to *develop her own concept* [my emphasis] (1966, p. 108).

This perspective is very different from that of many scholars who support the view that there should be a consensus of opinion regarding the role of the nurse and the unique knowledges that nurses must have to enact that role. The idea that nurses should "develop their own concept" suggests that there is more to the enactment of nursing than the application of standards or other such mechanisms.

Nurses following Henderson are faced with contradictions to the previously discussed frameworks of standardization and specialty practice. The suggestion that nurses should “develop their own concept” opens up a space for different perspectives and I would suggest different ways of enacting practice. Holding the view of patients, as individuals with individual goals can be taken as incongruent with the view of prescriptive practice through the use of standards, care maps and EBN. As previously stated, that is not to say that there is not a place for standards, perhaps care maps and certainly evidence. I suggest that following Henderson, individualized patient care is incongruent with a standardized prescriptive approach that holds patients to be homogeneous. Further competing with standardization, specialty practice, and individualized care, primary nursing was adopted as the care delivery model by the organizational restructuring project.

Primary nursing

According to Hegavary (1982), primary nursing is both a philosophy of care and an organizational model. Hegavary claims that the therapeutic aims of primary nursing include, less fragmented care, increased patient satisfaction, and increased quality of care all of which could be construed as a benefit to patients/families. There are ten components of primary nursing practice and these are; accountability, advocacy, assertiveness, authority, autonomy, collaboration, continuity, communication, commitment and co-ordination (Watts & O’Leary, 1980). These components could be construed to benefit nurses, as they appear to have more to do with enhancing the role of the nurse and his/her relationship with other health care providers rather than directly benefiting patients.

The primary nursing role is described as a particular kind of relationship between a nurse and a patient and the family. It is further described as an approach that is both patient and wellness focused (Cancer Agency, 1998b). However, in a 1997 clinic organizational document describing roles, the language used to describe oncology primary nurses (OPN) is remarkably similar to that used to describe the traditional nursing process. For example, a dimension of OPN role included these elements:

[He/She] Assesses, plans, implements and evaluates patient care in accordance with *established* nursing care processes and *standards* [and] provides physical care to patients, administers *prescribed* treatments [and] provides general psychosocial support [and] provides for the safety and well being of individuals in the environment [and] coordinates and facilitates patients and families' transitions between care settings and so on (Cancer Agency, 1998a, p.1).

There appears to be a lack of fit between the espoused beliefs regarding wellness and patient focused care and the language utilized in the role description. Guided to be patient and wellness focused on the one hand, the nurse is then intended to follow "prescribed treatments" and "standardized" patient care processes. This is just one more example of the competing aims embedded in the named nursing models such as, standardization, EBN, specialty practice, individualized care and patient/wellness focused. This study is concerned with exploring how oncology nurses practice in the everyday and how these various contradictory models or guides for practice are enacted.

Summary

In this chapter I have laid out a variety of authoritative frameworks that claim to guide oncology nursing practice. I have explicated that conceptually there are many contradictions between and amongst these and yet they are held out as if they shape practice. Given the competing aims and contradictions of these so-called guides, I advance an argument that oncology practice cannot be fully understood or explained

solely by in these particular conceptual terms. As a leader I am interested in how nurses manage to practice in the face of these contradictions and what other knowledges they draw upon.

Following Foucault and Giddens I take oncology practice as productive, influenced in the context of organizational, leadership, physician, and patient practices to name a few. Nursing practice understood as a predictable series of activities enacted by specialist nurses is limiting, as it does not take into consideration that professional claims are only one influence to how nurses come to enact their practice. Field work in this study is designed to expand the current thinking regarding practice by observing practice in the making and examining the “way the masses are lead”. By laying practice transparent, nurses and leaders will increase their repertoire of ideas about how practice proceeds and therefore what strategies might positively enhance practice, and lead to positive patient outcomes. In the next chapters I outline the sites where this study took place, the nurses, the methodology, and the method of analysis used in this study.

Chapter Four: Study Design

The Settings

In Canada, Cancer Care is frequently deemed to be a provincial responsibility and each province has established a mix of treatment and diagnostic facilities for ambulatory and in-patient care. In addition to these specialist centres, cancer care is carried out in the local hospitals, and community settings in every town and city by general nursing and medical practitioners who can refer to the specialist centre as needed. This study was conducted in two of the specialty ambulatory care centres in one Canadian province.

Ambulatory care became a setting focus because it represents a rapidly growing cancer care delivery system. The increase in ambulatory care has occurred in part to meet the increasing demands of a growing oncology patient population, but also as a response to fiscal restraints and health care reforms that call for decreased hospitalization (Lamkin, 1994; Nevidjon, 1993; Pluth, 1993). Pippy (2001), reviewing the oncology nursing literature suggests that although much has been written about oncology nursing, “much of the literature I found is theoretical and instructional, focusing not on what or how the work actually happens, but on the writer’s ideal of what oncology nursing should or shouldn’t be” (p. 4). She goes on to indicate that there is little written about the growing oncology ambulatory practice of nurses and she calls for increased research in this area.

Meadowview Clinic is a full service ambulatory centre that had been operating for approximately 5 years at the time of this study. Brookline Clinic is also a full service ambulatory oncology clinic located in a different city and had been in its present location for 15 years at the time of the study. Both clinics come under the umbrella of a large provincial cancer organization. Each clinic is locally managed but each reports to an

executive team. Both clinics are adjacent to a 'host acute care hospital' serving the same catchment areas. The clinics have purchased service agreements with their host hospitals for many services such as housekeeping, lab and x-ray services. While the majority of patients attending each clinic live in the city where the clinics are located, other patients may have to travel as much as 3-4 hours for an appointment.

The cancer organization operates on a program management model that was the result of a re-structuring change initiative undertaken in 1996/7. The major programs include, surgery, medical oncology, radiation oncology, and rehabilitation (rehab) services. Nurses are hired by a specific program and then are assigned to one of several clinics or program areas, for example, chemotherapy. Nurses report to a leader who is responsible for that particular program area. The leader may or may not be a nurse.

Professionally, nurses have a link to the Professional Practice Leader Nursing (PPLN) in their particular clinic. The PPLN job description indicates that they are responsible for "work[ing] collaboratively with regional leaders, academic settings and the community to plan, direct, and evaluate nursing professional practice in the care of patients/families with a cancer experience" (Cancer Agency, 2000, p. 1). The PPLN role is a resource for the nurses in relation to practice or professional issues.

Services provided at both clinics are similar and include; new patient consultations and follow up visits, chemotherapy and radiation treatments, nutrition and counselling services, and long term symptom management. In addition, nurses link with outside agencies such as home care nursing services, hospice, palliative care services, other hospitals, and long term care facilities on a patient specific basis.

Physical Layout

Meadowview Clinic

Meadowview as mentioned previously was built in 1995 and was five years old at the time of the study. There is a large parking lot at the back of the building designated by a sign for patients/visitors of the Cancer Clinic. Staff parking is in designated lots some distance from the clinic.

Upon entering Meadowview, there is a large area with couches and comfortable looking chairs. Directly in front of this area is a large counter and the sign above the counter is 'registration.' Typically there are one or two persons who fulfill a receptionist and clerical role behind the counter. Between these two staff patients are checked in and directed to the appropriate areas. The ambulatory clinics are to the far right of the front entrance and down the hall from this reception area. There are three designated clinic areas A, B and C. Each clinic area has a smaller version of the waiting room in the main entrance and a smaller version of the reception desk with a clerk sitting behind it. The waiting area has windows that face an open courtyard and there are pamphlet racks containing a variety of patient information on both walls that frame this area.

There are exam rooms, a washroom (unisex), a conference room and a shared clean/soiled room in each of the three clinic areas. At the back of the reception area is a work area with a computer, x-ray viewing boxes, telephones and chairs where the clinic staff (physicians, nurses, and others) confer, document and dictate patient notes.

The chemotherapy room is to the right of the main reception area down the opposite hall from the ambulatory clinics. Immediately outside this area is a small volunteer space where patient materials and information are kept. There is also another

entrance immediately adjacent to the main entrance of the host hospital and the covered parking lot that services hospital patients and visitors.

Inside the chemotherapy area there is a waiting space and a reception desk with a clerk behind the desk. Along one wall of the waiting area is the pharmacy, designated by a sign that says "Pharmacy, Ring for Service" on the window. From the waiting area, through a door, one enters the chemotherapy room that has 4 sections divided by half walls. In the far section there are two recliner chairs, in the next section there are four recliners, in the next section there are 2 recliners, and in the fourth section there are two stretchers. There are large picture type windows in the sections with the recliners. The rooms look onto a busy road.

In each of the sections there are IV poles, pumps and various medical, surgical supplies. There is one main desk area used for chemotherapy preparation that is adjacent to sections 3 and 4. At one end of the room is a Dutch door to the pharmacy and typically the top of the door is open. At the back of the room is the office for the PPLN, a soiled utility room, a staff washroom and a small area for 'overflow patients'.

To the immediate left of the main reception area are the patient and family counselling and nutrition offices. Left of this area and down the stairs is the radiation therapy department. There is a large waiting area immediately at the bottom of the stairs. To the left of this is a change room for patients to put on gowns. There are 5 radiation rooms in a U shape around the perimeter of this area. Each of these rooms has an anteroom from which the procedure can be directed, and the room itself where the patient has their radiation treatment. To the right of the waiting area there are 3 small exam rooms where patients undergoing treatments are seen for follow-up. Adjacent to the

exam rooms is a large workroom where the nurses draw up medications, document visits and collaborate with physicians and radiation therapists about patient issues. The rest of the downstairs area is comprised of offices and other radiation preparation rooms that were not included in this study. The first floor plan of Meadowview is shown in Figure 2 and a clinic area is depicted in Figure 3.

Figure 2, Meadowview Floor Plan.

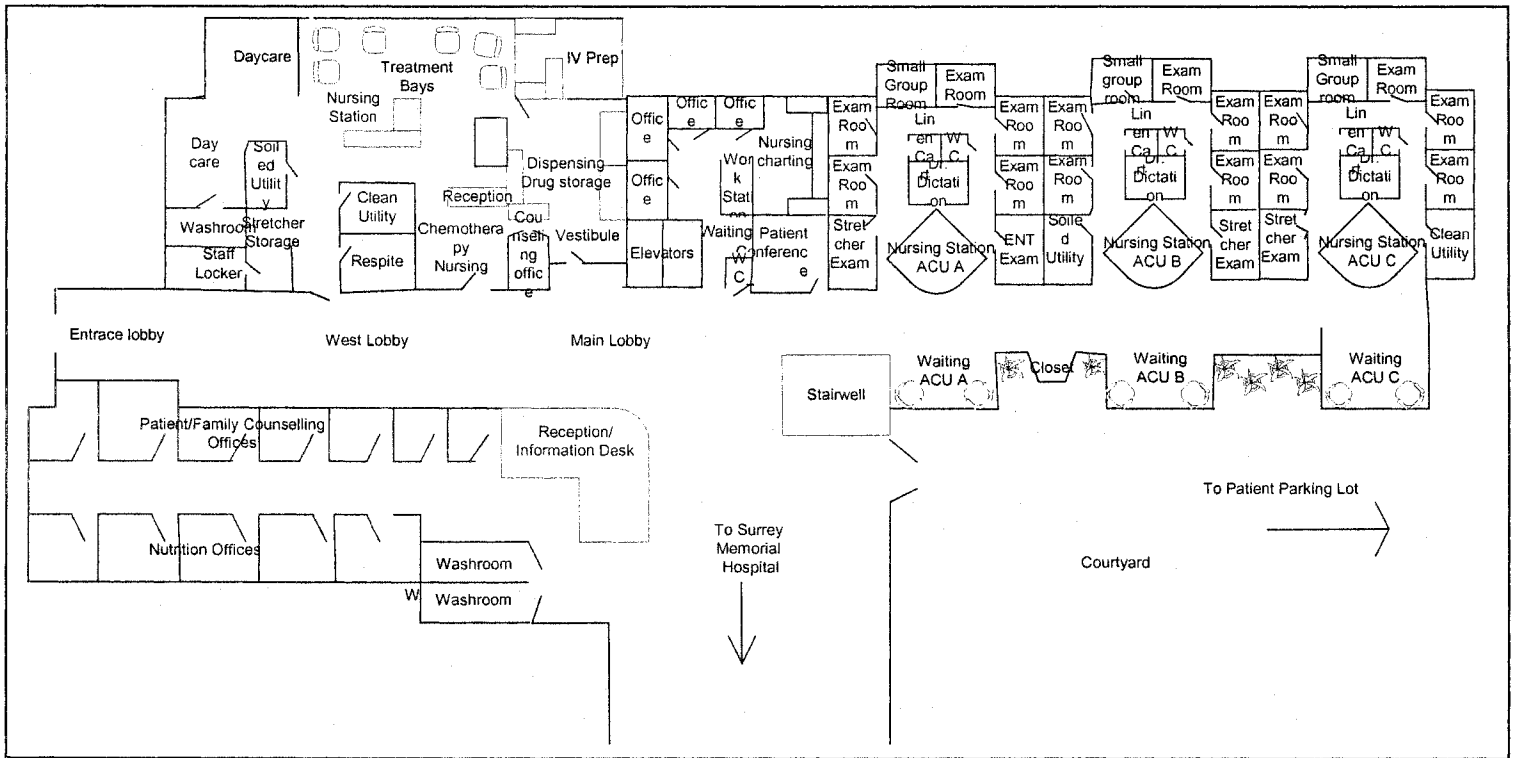
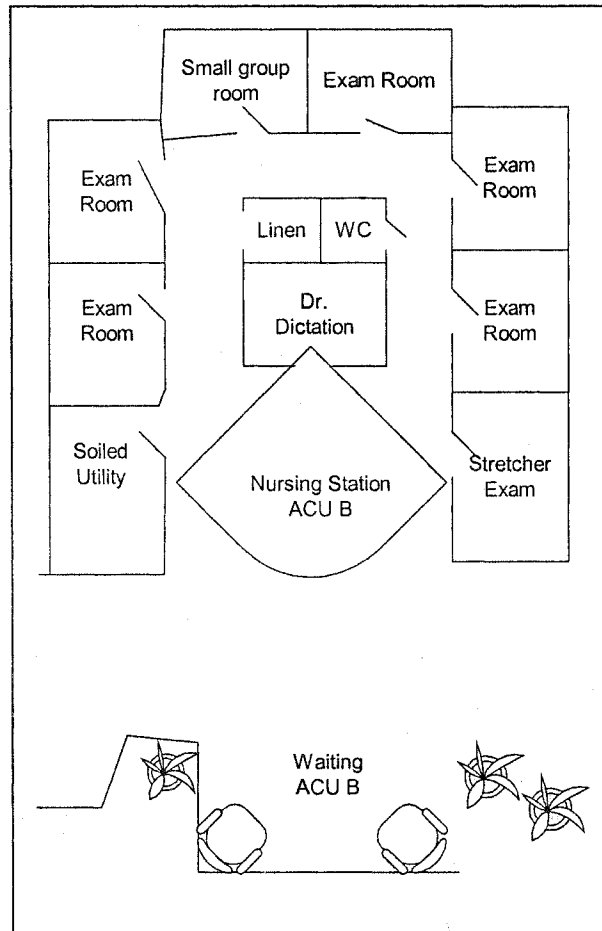


Figure 3, Meadowview Clinic



The second floor of the building can be accessed by elevator and includes the administrative offices, a small library that provides information for staff and patients, health records department and wing of physician personal offices with secretaries. The telephone management office at the time of the study was also housed in the administrative office area. The 'host hospital' is connected to Meadowview through a very short walkway just past the patient and family counselling and nutrition offices. Staff and patients at Meadowview utilize the hospital cafeteria services.

Brookline Clinic

Brookline was built in 1986 and was fifteen years old at the time of this study. The building was considered to have been cheaply built and not big enough to manage the volume of patients who lived in the catchment area. A new building was being built and there were plans to move into these new accommodations approximately one month after the completion of my data collection.

The main entrance to Brookline is located and connected to two of the buildings of the host hospital. Entering Brookline, there is a second set of doors immediately ahead. Turning to the right and down a hall and corridor one would enter the main entrance of the host hospital. Turning to the left and down a hall one would enter a hospital nursing unit. Proceeding through the second set of doors, there is a very small waiting area with six chairs and an equally small reception area with a receptionist/clerk sitting behind the desk. This is the only entrance for patients and all new patients register in this area and sit in the waiting area awaiting their first appointment. There are 3 very small exam rooms to the left and around the corner from the reception area. Adjacent to these rooms is a small work area with a computer, phone, and several chairs. At times

there are two nurses, one or two physicians and a clerk sharing these spaces. This area is referred to as Pod C.

Farther down the hall and on the right hand side is a small glass partition with a small desk where the nurse in RT (radiation therapy) does his/her patient documentation. There are also two patient washrooms for men and women. Around the corner to the left and then right is the radiotherapy department. There is a waiting area outside the department and reception desk where there is a computer for the patients (to look at patient information or play a card game) and print patient information materials. Volunteers maintain this area. There are 3 radiation vaults and by all accounts the rooms are small. There is a small work area where patient reviews are conducted. No actual observations were conducted in this area.

Beside the RT nurse's workstation is an elevator to the second floor and also a short set of stairs that go up to the second floor. Coming off the elevator one is faced by a large desk area that is divided into two by a partition. To the left of this is Pod A which consists of 3 small exam rooms and a small work area for clinic staff.

To the right off of the elevator is a large waiting room where patients who have ambulatory clinic appointments wait. Further on to the right there are physician private offices and secretarial-shared areas.

Walking straight ahead off the elevator, beside the divided reception area, to the left is Pod B that has 4 very small exam rooms and a small work area similar to Pod A. Around the corner from B is a small waiting area to the right with 4 chairs and the pharmacy to the left. Connected to the pharmacy is the chemotherapy room that has six recliner chairs. There is a small medication preparation area, a clerical area where a clerk

sits some of the time and there is a window that can be opened between the pharmacy and the chemotherapy room.

Outside of this area are two small rooms with stretchers in them for patient treatments such as dressing changes or for those patients that prefer to lie down during treatments. To the right of this is a small office that served as telephone management office. The administrative offices were housed in a different building. There is a small lunchroom in the basement level although staff and patients have access to the host hospital cafeteria. The floor plan of Brookline is shown in Figure 4 and a clinic area is depicted in Figure 5.

Figure 4: Brookline Floor Plan.

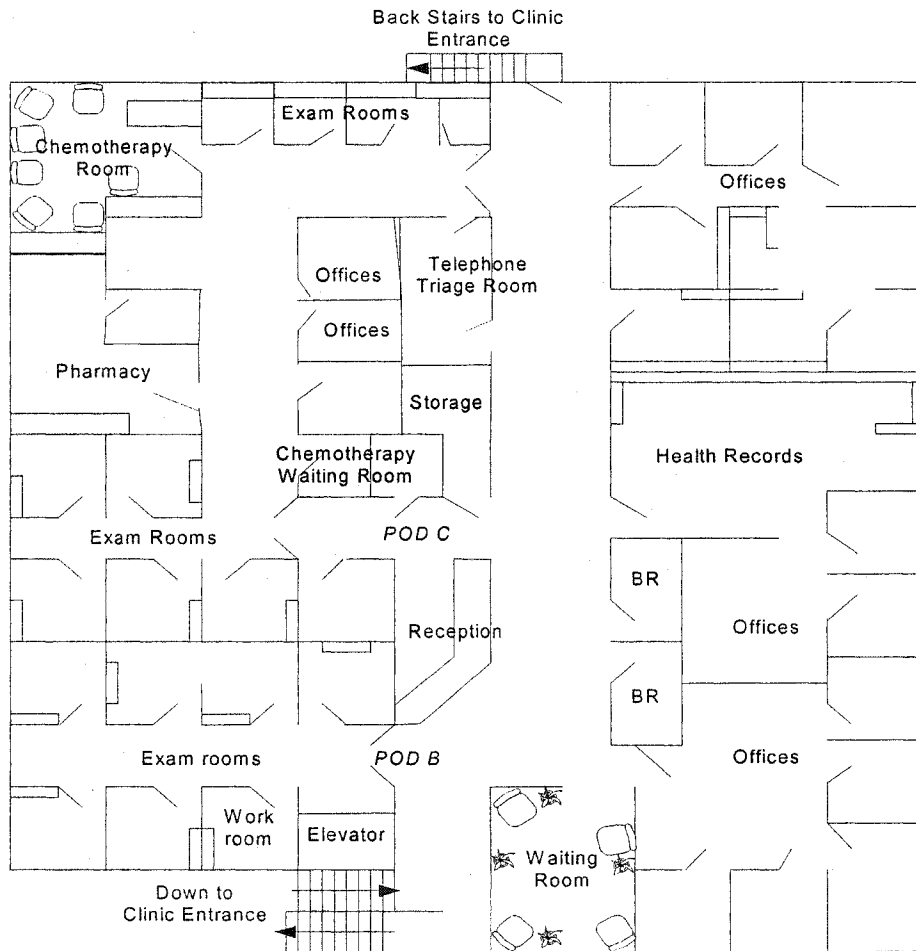
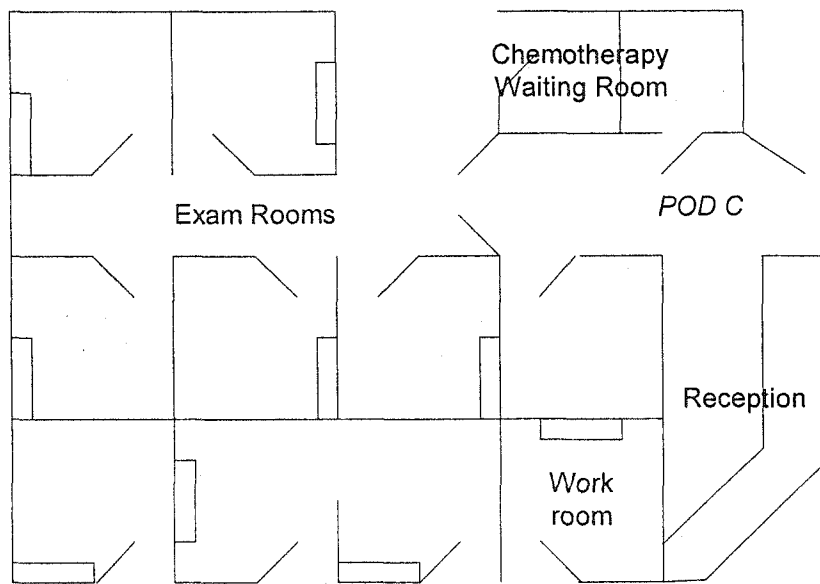


Figure 5: Brookline Clinic Area.



Negotiated Access: Gatekeepers and Sponsors

Getting in

Street (1992) following Hammersley & Atkinson (1983) indicates that negotiating access to formal settings can be difficult as there can be a blurring between those who act as gatekeeper and those who might be presumed to be a sponsor of a study such as this. The difficulty arises when one is unable to figure out how permission[s] is granted and who indeed makes the decisions. As in Street's experience, I too relied on informal sources [sponsors] to assist me to identify both the formal and informal processes that would be necessary to ensure that my study was properly approved in each of the clinics.

I first approached the chair of the Provincial Research Committee. I had been led to understand that this committee acted as the research review committee for the entire organization and therefore I initially believed that my research proposal would have to be approved by this group. However, this was not the case, as the role of this committee was in flux during the time when I was seeking approval. The local university had taken over the ethical review process for all of the clinical trial studies that had a principle investigator that was employed by the agency. Therefore, the role of the committee had changed and clarity regarding that change was ongoing. I also was concerned about sending my proposal to this committee as at the time of my study the membership reflected a positivist approach to research and I had considerable concerns that mine might be rejected. I also found out during this meeting that there were local (clinic specific) research committees that I would need to have approval from before proceeding.

I then met with the operations leader at each of the two clinics where I wanted to conduct my study. They provided valuable information regarding the concerns that

would be raised by other leaders at the clinics. Each indicated that if the university gave ethical approval for Human Subjects Research, then the concern that the individual clinic leadership groups would have would be related to resources required to do the study. The resources required for my study entailed freeing up the participant nurses for their audiotape interview, which took approximately 1.5 hours each. In addition, they indicated that the consent process would be scrutinized fairly rigorously and should be quite transparent. Each of these leaders indicated their support and as they each chaired their local leadership committee, I saw them as gatekeepers to the clinics

I followed up on their advice and made appointments with the nurse leader at each of the clinics to outline my study and the resources that would be required for my data collection. Each of them expressed an interest in the study. One leader was conducting a qualitative research study as a requirement for her Master's degree and the other leader was very aware of qualitative approaches and saw this as an opportunity to gather some valuable information about oncology nursing practice. I considered their support critical, as they would be the ones who would be responsible for giving the nurses permission and freeing up their time to participate. I considered them as sponsors as their interest in my study went beyond direct benefit to the clinics but also included indirect benefit to nursing as a whole.

I received ethics approval from the university November 2000 (Appendix 1). Following receipt of this approval, I wrote a brief proposal to each of the clinic committees seeking permission to conduct my study. I outlined the purpose, methodology and consent procedures that I would utilize and included copies of the consent forms. Meadowview Clinic leaders wanted a copy of the ethics approval from

the university and Brookline leaders approved my proposal with the proviso that I complete my data collection before their move to the new building. I sent both committees a copy of the ethics approval letter from the university and agreed to discontinue my data collection at Brookline before the move date. I then received approval from each committee, one by e-mail, and the other in a letter.

Clinic Staff

Nursing staff

Twenty-seven staff nurses are employed at Meadowview and thirty-two are employed at Brookline. Approximately 5% of the nurses hold a baccalaureate degree in nursing and approximately 55% hold a certification in oncology nursing (CONc). The nurses range in age from 26-52 years at Meadowview with the majority being between 40-45 years. At Brookline the age range is from 25-54 years with the majority being between 45-50 years.

During my meetings with the nurse leaders at the clinics during the approval process, I was invited to attend one of their staff meetings to explain my study, and to seek expressions of interest to participate in my study. Given that I held a leadership position within the organization, I was careful to design the consent process in such a way that there was a third party available who was not involved in the study and who was willing to act as a contact person for those nurses who expressed a willingness to participate. This person would also be available should nurse participants have any concerns during the study.

I attended a staff meeting on November 9, 2000, at Meadowview and on November 20, 2000, at Brookline. At these meetings I discussed the nature of my study,

what I hoped to accomplish and the expectations that I would have of the nurse participants (Appendix 2). I indicated that participants would not be referred to by name and that efforts would be made to ensure their anonymity by referring to participants as N1, N2 and so on. Nurse Leaders, similarly, would be referred to as NL1, NL2 and so on. Following my presentation, I opened up the meeting to any questions that the staff might have.

There was much discussion regarding the purpose of the study and speculation about what I might 'see' when I was doing my observations. Several staff indicated support for the idea of looking at practice in-depth, as "they don't know what we do." Several asked questions about time commitments outside of the observation periods. I indicated that I would require approximately 1.5 hours of their time for an interview. The nurse leader at each clinic indicated a willingness to facilitate freeing up the participating nurses so that they would be able to have their interview on work time.

During these staff meetings, questions arose regarding the consent process. None of the staff understood the need for the third party to vet their willingness to participate. They suggested to me that it would be important to make sure I had a nurse from radiation therapy in my study as that was an area of oncology nursing that most often was ignored. Several indicated a willingness to participate and wondered if they had to go to the third party or could they just tell me then. I suggested that they read the materials that I had prepared for them, and that they could contact the third party or me in a week to reaffirm their willingness to participate. At the end of each of the staff meetings I had nurses volunteer and during the next week I had additional nurses who indicated a willingness to participate. In addition, 4 nurse leaders, 2 at each clinic volunteered, for a

total of 8 staff and 4 nurse leaders. I gave each of the staff nurses and the nurse leaders a consent form. The staff nurses gave me their signed form at our first observational date and the nurse leaders returned their signed form at the time of their interview (Appendices 3 and 4).

Eight nurses and four nurse leaders agreed to participate in my study. Of the 8 nurse volunteers, 5 were at Meadowview and 3 at Brookline. At Meadowview the participants' ages ranged from 37-51 years and at Brookline from 36-54 years. One nurse at each of the clinics had a BSN and 6 of the 8 had a CON(c). Both of the nurse leaders interviewed at Meadowview hold a Master's degree and in Brookline one nurse leader holds a BSN and CON (c) and the other a PhD in nursing.

The nurses in the clinic are typically assigned to the chemotherapy room, the ambulatory clinics or the radiation review area. It is seldom that nurses are involved in all three areas. For example, a weekly assignment might consist of ambulatory clinics and chemotherapy or ambulatory clinics and radiation review. The participants in my study were primarily assigned to the ambulatory clinics and the chemotherapy room. One participant only worked in the ambulatory area due to health reasons and two nurses had assignments in the radiation review area. Four of the eight participants worked full-time and the other four worked part-time in various configurations. Three of the nurse leaders interviewed worked full-time and one worked four days a week.

Negotiating access to individual staff nurses once they had volunteered proved to be more problematic than I originally anticipated. Four of the eight participants worked part-time and their availability was limited to certain days of the week. Additionally, all of the staff had vacation days, sick days and EDO (earned days off) that occurred during

the period of data collection. Given that the clinics were in two different cities, several times I travelled to one clinic only to find that the nurse I had arranged to observe was not at work. When this happened, I often was able to observe one of the other participants. At other times I utilized the time to examine organizational documents.

Interview times were arranged with each of the nurses and the nurse leaders at their convenience and were held throughout the 3-½ month data collection period. The interviews took place in a private office at each of the clinics. Interviews were audiotaped and took approximately 1 ½ hours each, and followed a broad schedule of questions described in Appendix 5.

Non-nursing staff

In addition to nursing staff, there are various types of clerical staff that work in the ambulatory clinics, chemotherapy and radiation therapy areas. The clerical staff have responsibility for making patient appointments, filling out requisitions, booking tests, and ensuring that the patient chart was in order for the clinic appointments. They are often the first person that a new patient encounters and they also play a role in transmitting phone calls from patients to either the telephone management area or to specific nurses.

The physicians consist of approximately eleven medical oncologists (specializing in chemotherapy) and ten radiation oncologists (specializing in radiation therapy) at Meadowview, and fifteen medical oncologists and fourteen radiation oncologists at Brookline. These physicians work in the ambulatory clinics at both study clinics and see new patients for treatment recommendations. They also see follow up patients on treatment and also those who have completed treatment. Typically they do not see patients in their private offices in the clinic. They all have protected time for academic

and research purposes. They are considered employees of the main cancer agency in that they are paid on a contract basis and not paid fee for service.

There is a range of staff available to patients who come under the umbrella of the Rehabilitation Network. These staffs include social workers and nutritionists who are employed by both clinics. They see patients in all parts of the clinic and also in their private offices. Physiotherapists, occupational therapists and speech and language therapists are also available to patients although their services are contracted through the host hospitals. Therefore patients may be seen either in the clinic or in the host hospital if they require the services of these professionals.

The other group of staff that play a role in both clinics are the volunteers. Each clinic has a cadre of volunteers who provide a wide variety of services to patients including assisting in the library, keeping information racks full, distributing tea/coffee/juice and snacks to patients and visitors, chatting with patients who are alone and so on.

Patients and Families

People requiring the services of the clinics are referred to by clinic staff as either patients or clients. For the purposes of this study I refer to these persons as 'patients' as that was the term that I most often observed being used by staff and by people when they identified themselves. For instance persons talking to each other in the waiting room were observed to say, "I am Dr. Smith's patient". Also when they identified themselves to the receptionist, persons were observed to state, "I am a patient of Dr. Jones", and "I am here for an appointment with her". I never heard a person identify himself or herself as a client. Professionals occasionally referred to persons as clients when talking with one

another and the term client was found in some of the organizational materials that I reviewed.

As the purpose of this study was to explore the work of oncology nurses, I often observed their interactions with patients and families. Over the course of my observational period I observed the eight participating nurse interactions with well over two hundred patients and multiple more family members, and friends.

The patients observed ranged in age from approximately 19-84 years old. Most patients lived in the cities where Meadowview and Brookline were located, but several travelled 3-4 hours for their appointments. They came to the clinics for a variety of reasons. These included: initial diagnosis of their cancer and discussion about treatment options; chemotherapy and radiation treatments; pain and symptom management clinic appointments; follow-up appointments while still on treatments and for a period of time following treatment completion and, combinations of the foregoing if their cancer had progressed or reoccurred.

The patients I observed had a wide variety of different cancer diagnoses and also there was wide variation in their life expectancy because of their cancer. On the surface their appearance ranged from fit and healthy looking to acutely ill to terminally ill. The only discernable similarity was that they all had a cancer diagnosis.

Participant access: Patients

My initial intent was to obtain written consent from each patient that the nurse participants interacted with. Additionally, I had intended to ask one of the clerks to call potential patients ahead of time to obtain a verbal consent to participate. I would then follow up with a more complete explanation and written consent when they came to the

clinic. This procedure did not turn out to be practicable due to the nature of how the ambulatory clinics and the chemotherapy rooms are organized. The nurse assignments are not finalized until the morning of each clinic day. Therefore, it was unreasonable to phone patients only to find out that the nurse assignment was changed due to a variety of reasons, for example a sick call. Nurses also often work in pairs in the ambulatory clinic and depending on the workload, their assignment would change during the clinic. Thus, they might end up seeing different patients than those originally assigned.

In the chemotherapy room at Brookline, nurses did not have a patient assignment. The first available nurse treated the next patient on the list. Therefore it was impossible to anticipate which patients would be interacting with the study nurses. Additionally, study nurses often interacted with several patients in the chemo room depending on the patients needs, or if they were covering meal breaks and picking up for another nurse.

After discussion with my two of my committee members I adapted the patient consent process as follows. When I was conducting my observations in the chemo room, I left bright orange notices at the reception desk next to where the patients checked in.

The notice state,

Today in the Chemo room a study is being conducted. A nurse research student is doing a study about nurses' work and is observing nurses in the chemo room and making notes of these observations. If you have any questions, please ask one of the nurses and they will have the nurse researcher talk to you. Thank you.

I also placed these notices on the coffee tables in the chemo waiting room. Therefore consent was passive, but in this way I informed patients that there was a possibility that their time in the chemotherapy room was being observed. Several patients commented

when they noticed me observing and several asked me about my study. None indicated either directly or indirectly that they did not wish to participate in the study.

In the ambulatory clinic areas, the nurse participant asked the patients for permission for me to approach them using a prepared script (Appendix 6). If the patient agreed to speak with me, I briefly described the study, and if the patient agreed to participate, she/he signed a written consent form (Appendix 7). Typically their interaction with the nurse occurred immediately after this process. Very few questions arose during this procedure. Patients were primarily concerned about whether participating would take any additional time or if they would have to do anything else other than being observed. When I indicated that there were no additional requirements all agreed to participate.

I was very sensitive to the imposition my observations might have on patients and families during what might be considered an extremely vulnerable time, particularly those receiving unfavourable information about their condition. During these instances I would verify their willingness to have me continue to observe. On four occasions I absented myself from a nurse-patient interaction. In two cases, I believed that the patient did not understand the nature of the study due to a language barrier. In one other case the nurse suggested that the patient was not appropriate due to extreme frailty and, in another because of the terminal nature of his illness.

Access denied

On two occasions, one physician refused to have me present while he and the nurse discussed the diagnosis with the patient and family member. In the first case, the patient had given permission, signed the consent but the physician came up to me and

stated, “ I didn’t want you in there as I thought it would be too difficult”. In this instance once the physician/nurse/patient conference was completed, I again joined the nurse and patient for the final interview after reconfirming the patient’s willingness to have me present. In the second case, this same physician indicated to the nurse participant that it was not appropriate for me to observe the interaction, as the patient was a former politician.

These two physician situations occurred very early in my data collection and perhaps may have been because the physician was not aware of the nature of my study. Following these occurrences, I sent out an email to all staff at each of the clinics informing them who I was and a brief explanation about the study I was conducting. I was very vigilant about informing all staff who I came in contact with that I was observing the participant nurses’ interactions and that if they were concerned about being part of my observation[s] that they should not hesitate to let me know. I had many questions from staff while I was observing, but none indicated an unwillingness to have me observe their interactions with the nurse participants. One of the pharmacists commented that she wished someone would do a study of pharmacists, as “no one knows what we do either!”

Research Materials

Observational and interview materials

As indicated previously, this study is concerned with compiling accounts of oncology nursing practice. This compilation includes direct observations of the interactions of nurses with patients, physicians, clerks, each other, others and me. In addition, I examine other features of oncology nursing practice, such as patient charts,

organizational documents including policies and procedures, schedules, and taped interviews with nurses themselves in an attempt to capture a textual perspective of the everyday.

Using multiple data sources also provides a basis for triangulation of the data (Hammersley & Atkinson, 1983; Hammersley, 1990).

Triangulation has typically been used to check on the validity of descriptive claims. According to Hammersley (1990) the premise behind triangulation is, given that all data have different threats to validity, by comparing different sources of data “we may be able to make a more effective assessment of the likely truth of the claim” (p. 84). The claim of authority in a post-structuralist epistemology is denounced by Lincoln and Denzin (1998) who suggest that any notion of a *valid* text “can be undone in terms of its external structural logic” (p. 415). In conducting my research in two different cancer clinics I set up the conditions whereby I am also able to cross check my observations with my taped interviews across two settings.

In the analysis, the first site Meadowview has been analyzed and research material from the second site, Brookline have been used to check on the findings from the first analysis, and compare and explain any differences in the way in which nurses constructed their practice and conducted themselves. Purkis (1994) critiquing Benner suggests that the absence of crosschecks “place limitations on the claims made by Benner” (p. 332). Therefore, cross-checking my observational data source with a critical examination of the taped interviews and documentary data provides both a contextualized description of oncology nursing practice and evidence of triangulation and a cross check of the data.

Fieldwork took place over a three and a half month period of time divided as follows: I spent approximately fifty-five hours at Meadowview and twenty-five hours at Brookline for a total of approximately eighty observational hours.

Fieldwork was configured around the typical work conducted by eight oncology nurses participating in the study, five from Meadowview and three from Brookline. One participant went off on sick leave during the study and her data was excluded in the analysis, therefore in the end there were seven observational participants. Observations were made of multiple aspects of oncology nurse's every day work as it was enacted over the observational period of time. This included, nursing report, nursing meetings, patient visits in the ambulatory clinics, chemotherapy administration, and radiation therapy follow up clinics and telephone management. I recorded both the talk and actions that occurred during these periods. I reviewed patient documentation, organizational documents related to care delivery models, organizational change initiative reports, meeting minutes, and other documents that provided a contextual backdrop for the nurses' work. In addition to interviewing the seven observational nurses, I also conducted interviews with four nurse leaders, two at each of the study clinics.

Constructing a text

A field researcher attempts to describe situations and encounters in enough detail to portray another's [subject of study] way of life (Ellis, 1996; Emerson, 1983; Emerson, Fretz & Shaw, 1995; Rudge, 1996). The difficulty of course, is knowing how much is enough detail. Following Geertz (1983) I made field notes that attempt to capture events that I observed in order to recount, "what happened in fine detail" (p. 23). This entailed making notes that describe the basic settings, present dialogue between people, and also

that provide a characterization of what is going on. Emerson et al. (1995) indicate timeliness of transcription facilitates “detailed descriptions of the processes of interaction through which members of social settings create and sustain specific, local social realities” (p. 14). Therefore, during my fieldwork I attempted to transcribe my notes while my observations were fresh at the end of each observational encounter or at the latest the next day. Nurse participant’s identity was protected by referring to them as N and a number such as N1, N2 and so on. The nurse leaders likewise were referred to as NL and a number, NL1 to NL4.

My observation notes consist of as much as possible a word-for-word record of what was said by nurse participants during their interactions in their various activities within the cancer clinics. These interactions include those with patients, staff, physicians, family members and so on. In addition I recorded the actions of the nurse participants as they engaged in their day-to-day activities. These activities consisted of approximately eighty hours of observations and include direct care to oncology patients, attendance at meetings, report time, staff meetings and coffee breaks.

I also conducted eleven interviews with the seven participant nurses and four nurse leaders about how nurses conduct their everyday work (Appendix 5). Although it is never possible to capture all that one sees and hears during an observation, I am confident that the comprehensiveness of my observations and note taking during the period of my fieldwork can be construed as representing the day-to-day activities of oncology nurses in the two cancer clinics.

The discourses of nursing practice as depicted in both the written [literature] and verbal [talk] accounts of practice have lead nurses as practitioners and leaders to assume

that nursing practice is predictable and proceeds in a logical manner. The verbal accounts of practice are taken to be sufficient to represent practice. Nurses are assumed to apply nursing research to inform their practice. Nurses talk about and account for their practice based on their personal experiences and this talk is taken to fully represent practice. These accounts, written and verbal, represent different forms of nursing text and as such can be read for the purposes of research. This study is concerned with how oncology nurses have come to account for their practice, how their practice proceeds in the clinical setting and how these can be read as text. The research approach to organizing and analyzing this text will be discussed in the next chapter.

Chapter Five: Examining Practice - A Research Approach

Characteristic of [paradigmatic] shifts is the phenomenon that in times of transformation, not only do new problems arise; *old ways of looking at problems become problems themselves* [my emphasis] (Jacques, 1993, p. ix).

Introduction

The first four chapters laid out how the delivery of health care services and nursing practice has been depicted in the literature. Health care service delivery has moved from concern about public health to concern for types of services modeled on medical specialties, such as oncology. The prevalence of an economic, business view of health care has resulted in numerous attempts to change health care delivery in the name of efficiency and fiscal responsibility. Efforts to re-form, re-engineer and rehabilitate the health care system have met with modest success as many of these initiatives are based on a decontextualized view of how health care is delivered. Organizational changes such as that undertaken by the cancer agency, provides a case study to explore how the aim of fiscal efficiency and improving patient care have come to be played out in the everyday of oncology nurses.

The nursing literature characterizes nursing practice as a predictable series of activities that are learned by applying particular types of 'scientific' knowledge (Allgood & Chong Choi, 1996; Hiraki, 1992; Whalley & Wong, 1983). Nursing activities are often framed in the contradictory discourses of academic, professional, and organizational aims. The patient is positioned as passive and nurses are instructed to divide their care by diagnosis, treatment, medical specialties and so on. Health care organizations are set up both physically and structurally to perpetuate these dividing practices. The description of the cancer clinics in Chapter Four illustrates how the field of oncology has been divided by program, treatment, and professional disciplines.

Nurse leaders are frequently called upon to account for nursing practice and to initiate or participate in changes to that practice. The manner in which nursing practice is talked about, and depicted in the literature provides an incomplete or narrow understanding of that practice. The effect[s] of this understanding as Jacques has highlighted in the quote above, has been that changes to practice are often based upon “old ways.” In the face of the prevailing and dominant economic predictions regarding health care costs, it is incumbent upon nurse leaders to develop new ways of looking at old problems so they do not become a problem themselves. They must position themselves as informed voices for changes. How then does one deepen an understanding of practice and become an informed voice? This chapter outlines the research approach taken in this study.

Post-Structuralist Inquiry: Clearing a Space for Meaningful Practice

Qualitative research

Denzin and Lincoln (1998) explore the history of qualitative research and suggest “qualitative research has been haunted by a double-faced ghost” (p. 23). On the one hand it was thought that qualitative researchers were able to objectively and with clarity report on their observations of others. Secondly, it was held that the individuals being observed were able to report on their experiences. The result was that a researcher was somehow able to mix their observations with the narratives of their subjects and come up with an account of the human experience. Today, this position is challenged by a post-structuralist view that maintains, “there is no clear window into the inner life of an individual” (Denzin & Lincoln, 1998, p. 24). Researchers cannot claim to observe all there is to observe about a human experience and neither can subjects claim to give full

explanations of their experiences. Therefore, as a researcher I am left with the challenge of engaging in a research process that at best will offer a careful and systematic reading of practice. By offering this reading I hope to deepen my own understanding of such practices, share that reading with others, and over time, make use of that reading in planning and implementing changes in the ways nursing practice is currently conducted. One purpose would be to make that practice increasingly responsive to patient-held concerns rather than organizational and professional concerns.

In this study, I draw on post-structuralist theory to put forth a challenge to the existing taken-for-granted assumptions and understandings about developing knowledge about, and for, nursing practice. "Post-structuralist research points to the contradictions and presuppositions made on the assumption of any sort of claim to authority" (Heslop, 1997, p. 54). Hughes & Strurrock (1997) describe post-structuralism as resulting from a "loss of faith in the capacity of our schemes of thought, especially science to represent the truth about reality" (p. 185). I have lost faith in the rational model of management solutions. The belief that improvements to nursing practice and patient benefit occur through the application of theoretical knowledge negates the social context of practice. The notion of finding a solution outside of practice [that is at the senior management level] and then imposing that change upon practicing nurses ignores the possibility that nurses are active participants in constructing their practice. It is problematic to assume that the prevailing authoritative discourses of oncology nursing practice and health care management represent that practice in any sort of predictable way. Thus a different approach to studying practice is called for.

Post-structuralist approach

As discussed in Chapter Three, studies of nursing practice have primarily focused on *how* nurses apply some type of knowledge in the practice setting, based on the taken-for-granted assumption that practice proceeds in a predictable manner. This portrayal of practice implies that it occurs in a vacuum somehow immune to other influences - organizational, professional, educational or managerial. This simplistic view of practice is disrupted by critically reviewing how it is that practice does proceed in the every-day. The following is an example of such an approach.

Gibson (2001) reviewed and analyzed the literature related to “the nurse’s role in medication management, including knowledge required by nurses, practices and procedures related to administration, procedures for identifying and reducing errors and measuring error rates, and professional and ethical issues” (p. 108). Drawing on the work of Foucault, Gibson suggests that the literature is a “discursive practice” and as such contributes to how it is that nurses are “positioned in relation to medication errors” (p. 109). Gibson goes on to suggest that the discourses of medication errors in the literature are problematic as they contribute to a decontextualized view of nursing practice. She argues that nurses develop “alternate discourses” for their medication practices that takes into consideration the contextual aspects of their practice, such as, patient complexity and organizational practices.

Gibson suggests that the policies and procedures meant to guide medication practices practice need to be in a form that enables practice to proceed in a manner that takes into consideration the context of that practice. Baker (1997) also writing about medication errors indicates that nurses,

[To] survive and make life orderly, nurses use institutional policies and procedures to their own ends. Creating tactics to manage the complexities of practice. Such tactics provide instances of nursing knowledge, skill and decision making in the management of medications and highlight how rules and polices can be made more flexible so as to accommodate the realities of nursing practice. (p. 157).

These contextualized studies of medication errors drawing on post-structuralist methodology reveal the local subjugated knowledges elucidated by Foucault (1976) that somehow have been “disqualified [by nurses] from [their] hierarchy of knowledges and sciences” (p. 21).

Knowledges uncovered

Following a post-structural methodology, this study is concerned with revealing the tactics and knowledges both in the foreground and background that oncology nurses employ to manage their practice and the language that they use to explicate their practices. Ferguson (1984) suggests that bringing subjugated voices or knowledges to the forefront is one mechanism “to bring power to light and to alter that power” (p. 155). As discussed in Chapter One, following Foucault (1970, 1972, 1976), knowledge and power are seen to be reciprocal, each producing the other and not separable. Power is taken to be relational and involves both resistance and domination. Power-relations are apparent in all social interactions and relationships and frame the way in which the world is constructed and understood. Power has often been treated in nursing as punitive and limiting. In this study, power-relations will be revealed and explicated as generative and manifest in the working life of oncology nurses.

A post-structuralist research approach attempts to “make contestable and discussible that which has been removed from debate as having only one possible meaning: representations of the real, the true, the norm and common sense” (Hughes &

Sturrock, 1997, p. 186). The intent of this research is to make oncology nursing practice discussible in a different way. The knowledges that influence the enactment of oncology nursing are both broader and different than the traditional scientific knowledge taught to nurses in their school curriculum. I suggest that their knowledge is more than that which is included in the standards for oncology nurses crafted by CANO. Oncology practice is influenced by knowledges including professional, educational, and organizational, and this study reveals the conditions upon which nurses take up these knowledges. The description of nursing practice generated in this study will serve to inform nurse leaders about the knowledge that nurses draw upon in their everyday practice.

Following Law (1994), in this study I do not distinguish “a priori” which aspects may prove to be in the foreground and which in the background. Law suggests that indeed distinctions may arise, but that as the process is precarious “we should try not to treat the regularities that we discern as if they were different in kind from the contingencies. For they, too are effects like everything else, and they too, may be undone” (p. 4). Gibson’s (2001) study of medication errors reflects this impetus by including in her review a wide variety of both research-based and non-research-based articles in order not to “privilege one form of text over another” (p. 109). Gibson goes on to explicate that using post-structural analysis it is possible to identify those voices that are silent as well as those that are spoken. By not privileging one aspect of practice from another, as per Law, I remain open to the possibilities that oncology nursing practice as it is portrayed and accounted for in the literature, and the narratives of nurses and leaders may bear little or no resemblance to the conditions organizing its enactment in the everyday practice setting.

Truths, facts and generalizability

Hardin (2001) indicates that in a post-structuralist methodological approach it is not the intention to discover a truth, “but instead asking how truths are created by whom, and for what purposes” (p. 12). She goes on to suggest that although patterns of behaviour and language become automatic, analogous to brushing our teeth, a post-structuralist approach entail,

- (i) [A]sking what *meanings/truths* in this cultural and historical moment are declared significant, and conversely, which truths have been declared expendable;
- (ii) asking how normalizing truths produce particular kinds of people; (iii) asking how master discourses developed historically and what practices continue to keep them alive today; (iv) seeking out alternative understandings that have been concealed (remembering that which still is); and (v) exploring how it is that individuals negotiate and position themselves within and between master discourses (p. 17-18).

Following Geertz (1983), there is no world of social facts “out there” waiting to be observed, recorded, or analyzed by me (p. 19). This study focuses on how the “truths” regarding oncology nursing practice have come to be constructed in two oncology clinics, by whom and for what purpose. This study does not claim that the clinics in the study are typical of other clinics. Rather, this study is concerned with examining the practice in these clinics and how these practises relate to the existing views of oncology practice. Garfinkel (1967) refers to common sense knowledge of social structures or “common culture that people use in their everyday affairs and which they assume that others use in the same way” (p. 76). Following Garfinkel, the practice of oncology nurses can be viewed as a common culture and exploring the knowledge that is taken up to manufacture that culture is of interest in this study.

A post-structuralist theoretical stance disrupts the notion of one truth or one way of reading the text of oncology nursing practice and creates a space to explore other possible truths and knowledges that have been constructed in relation to practice. I chose an ethnographic study approach as this permits an examination of nursing practices that “attempts to challenge the contradictions in knowledge and action, which have been systematically distorted by history and ideology” (Street, 1992, p. 12).

Field Studies and Ethnographic Method

Ethnography

Emerson (1983) describes ethnography as a research method committed to “describing the social and cultural worlds of a particular group [and] the disciplined study of what the world is like to the people who have always lived in that world” (p. 107). Giddens (1984) expands on this notion of description and outlines a number of guidelines for the overall orientation of social research. He indicates that as the phenomena being studied is already considered meaningful, that the researcher must attend to “getting to know what actors already know, and have to know to get on in the daily activities of social life” (p. 284). In order to explicate what it is that oncology nurses know about their day-to-day practice, a field study such as this is one way to ‘get to know’ that practice.

Getting to know practice entails an exploration and examination of day-to-day practice by means of direct observation. The purpose of these observations are as Jacobson & Jacques (1997) suggest, “not to capture the variety of nurses’ experiences but to record the normal, the routine, the daily” in order to document a rich description of nursing oncology practice (p. 51). According to Geertz (1983), “like sailing, gardening,

politics and poetry, law and ethnography are crafts of place: they work by the light of local knowledge” (p. 167). Therefore, a central purpose of this field study is to lay transparent the local knowledge embedded in the practices of oncology nurses and unpack how those knowledges have come to be taken up by nurses.

Ethnomethodology: membership and accomplishments

Ethnomethodology according to Garfinkel (1967) “rejects explaining social order in abstract terms, in the interests of discovering and describing how social order is achieved in and through the activities of members of society” (p. 106). Language alone cannot be taken in isolation. Garfinkel suggests the constitution of day-to-day practice can be identified by focusing on how and what constitutes day-to-day practice.

According to Garfinkel, action/performance is read as a display and made visible.

Garfinkel (1967) indicates that how visibility and accountability are mutually constituting: accountability is that which is “observable-reportable” (p. 1). There is a connection between what is said, what is seen, and is done: what can be said constructs what can be seen and how objects can be understood. This is illustrated in Garfinkel’s study of jurors.

In this study Garfinkel identifies how jurors indicate that they modify their usual everyday decision making rules that constitute the “official juror line” (p. 108). In talking about the procedures that they used to make a decision, jurors identified that they followed the official juror line or the procedures outlined for them as jurors. However, observations of juror practices did not support these “ideal accounts”. Garfinkel indicates that when this discrepancy was pointed out to jurors, they were anxious and “looked to the interviewer for assurances that the verdict nevertheless had been correct in the judge’s

opinion” (p. 113). Garfinkel suggests that these accounts are themselves practical accomplishments. Members [jurors] make certain actions accountable because they fit into what is considered proper or rational or visible for a good juror. They know how to do “good juror.” Garfinkel is suggesting that the accounts of members, their actions, and procedures are in themselves constituted by the settings in which they occur. According to Mueller (1995) the “importance of accounts applies to those who are being studied as well as the researcher conducting the research” (p. 28).

Tulin (1997) similar to Garfinkel indicates that through talk and action, people produce and make sense of their world. Tulin suggests that every moment of social life is produced and that social life is a constant “collaborative work, weaving past and future into the present” (p. 106). By examining nursing practice utilizing field method informed by the epistemology of ethnography and ethnomethodology, I am not seeking to expose the truth of oncology practice but rather how visibility/accountability is accomplished by oncology nurses. Likewise, similar to Mischler (1984), my purpose is to “not exhaust the singular meaning of an event [oncology practice], but to reveal the multiplicity of meanings, and it is through the observer’s encounter with the event that these meanings emerge” (p. 10). I anticipated that the study participants, the clinic administration and other health care workers might be concerned with this approach.

Understanding/Changing Nursing: Methods of Inclusion

I anticipated some level of conflict and concern on behalf of the clinic nurses and leaders about what it is that I might ‘discover’ during my observations. Law (1994) addresses this type of concern in his study of a lab, “how should I try to overcome the [reasonable] fear that I would be in the way, make trouble, take up valuable time, or

discover potentially discreditable facts about the laboratory [oncology nursing practice]” (p. 36). One approach suggested by Heslop (1997) is that a relationship should be promoted in order to seek understandings from participants and to achieve a textual product that is not only the researchers. She further suggests that the researcher must position the research as “ a mutually participative creative process, wherein the contribution of the participants is valued and recognized in the research process” (p. 55). In this way Heslop argues, the participants are part of the research process and aware of the findings as they emerge.

However as Street (1992) points out, it is naïve to assume that nurses who participate in a study such as this have the same or similar understandings as the researcher. For example, Street suggests that as the researcher benefits directly from this research, in my case the award of a PhD, that it is unreasonable to suggest that the process can be truly mutually participative. The benefit to the participants is not transparent nor the same as for the researcher. Therefore, as a researcher and a nurse I am mindful of the differences in benefit from the study. I was vigilant to continually communicate to the nurses and whoever else was interested both about the study intent, and also and perhaps more importantly what the study was not intended to do. The information sheet that I sent to clinic leaders during the approval process was discussed at the staff meeting and I left additional copies in the nurses’ change room (Appendix 2).

This study provides a rich description (cf. Geertz 1983) of regular day-to-day practice, challenges the prevailing accounts of practice, and provides different understandings upon which to base practice changes. This study is not intended to be the final word on oncology nursing practice, but rather to provide a glimpse of the every-day

to see how that matches with the working assumptions regarding that practice. The intent is not to 'hurt' the oncology nurses or the clinic staff or reputation. However, as Law (1994) acknowledges, "to agree not to hurt [the lab] is not necessarily to be uncritical" (p. 39). As the researcher I critically examined the varying perspectives at both clinics and drew on the points of conflict to move the research forward. I attempted as a researcher to follow Street's (1992) example and "bring to the reader insights which are couched in a profound respect for her [my] research participants yet which challenge the very presuppositions which inform their daily practices" (p. 2).

Reading an Ethnographic Text

Representation and reflexivity

8pm, February 29, 1918, New York City

Dear Diary,

No, I will not use that form of address. That is a relic of childhood. This book will serve as a record of my progress as a singer. I will record only *relevant facts* that will prove useful as my training progresses. No gush. Let other girls record their crushes and their dresses, their tresses and trousseaux. I am here to work. I will note *scientifically* everything I learn as in a lab book. I will be *objective* and unflinchingly self-critical. I will not be distracted by the bustle of this city. And in this, my record book, I will not allow emotion to color my perceptions [my emphasis] (MacDonald 1996, p. 455).

This excerpt is taken from the novel Fall on your knees by Ann-Marie MacDonald. The diary writer is a young girl by the name of Kathleen who has traveled to New York City to become a singer. In spite of her efforts to be "objective, unflinchingly self-critical, and not allow emotion to color [her] perceptions", her diary entries are full of colorful descriptions of her day-to-day activities that include falling in love, having an affair, and singing in her first professional concert. In this opening entry in her diary, Kathleen reveals her belief that it is possible to somehow depict her human actions and activities as

if they occur in a vacuum unaffected by the world around her. In the past, qualitative researchers have also subscribed to the belief that it was possible to objectively observe human actions and activities. As a researcher, I subscribe to the view described by Denzin and Lincoln (1998),

There are no objective observations, only observations socially situated in the worlds of the observer and the observed. Subjects, or individuals, are seldom able to give full explanations of their actions or intentions; all they can offer are accounts, or stories, about what they did and why. No single method can grasp the subtle variations in ongoing human experience (p. 24).

Following Law (1994), “I am not a detached observer...and facts and values join together” (p. 39). As a nurse, I enter the field as an informed listener and one who has a different theoretical frame in approaching practice than those in my study.

Rosaldo (1989) critiques ethnographies written in the ‘classic’ mode and indicates that the notion of a value-free observer/researcher is a myth. He goes on to suggest that it is virtually impossible to “remove oneself from the mutual conditioning of social relations and human knowledge” (p. 169). That is, the inability to achieve “value-free” observer status is not to be understood as a technical failure on the part of previous methodologists, but rather, an ontological and epistemological state to be addressed.

Ethnomethodologists have addressed this state of social relations by developing an analytic approach to social situations that accepts actors’ participation in the world, including researchers’ participation in that world, as the condition of possibility for talk. According to Lynch (2000) “the ethnomethodological version of reflexivity is an unavoidable feature of the way actions (including actions performed, and expressions written, by academic researchers) are performed, made sense of and incorporated into social settings” (p. 27). For ethnomethodologists like Lynch, meanings are generated in everyday conversations entirely through reference to knowledge that is taken for granted

as that which “every member knows”(Garfinkel, 1967). That is, neither participants nor researchers can achieve a status above the fray from which to make a more secure statement about the ‘truth’ of the matter under consideration. Rather, “the concepts of reflexivity are diverse, and the implications of reflexive inquiry remain unspecified until we learn more about the relevant theoretical investments and contextual applications” (Lynch, 2000, p. 47).

This study is concerned with examining both the narratives of oncology nurses and observing their practice in the everyday, against a context of an organizational change initiative. The point of this type of examination and analysis is to reveal the theoretical assumptions upon which practice is said to be enacted, and the contextual features that impact that enactment. As a researcher, I too am an actor producing and accomplishing accounts, albeit from a privileged position. The status of my privilege is not just that I hold a position of authority within the setting from which the field work was conducted. Instead, I have made my observations and conducted my interviews from a position of having designed the strategies for observing and talking that are systematic, and therefore more robust than everyday conversations typically are. For instance, in everyday conversations with a nurse colleague who tells me that she is “having a wild day in the chemo room!” I might laugh and tell her that I know what she means. In this research, such a comment would be followed up with further questions about how it has come to be that this nurse, today, and at this time accounts for her encounter in the chemo room as “wild.” This privileged place permits my interpretations of practice to be held for a period of time, given that “readings occur within frameworks of inter-textuality” (Giddens, 1987, p. 107).

Analyzing text

The aim of the data collection was to collect research materials that would be analyzed at a later date. I did not begin my analysis until all of the research materials were collected. I attempted to be reflective during the data collection phase of my study by jotting down ideas and thoughts at the end of each observational session. This may be considered a form of analysis but I waited until I had completed my data collection, which became my text, before moving to the formal data analysis phase of the study.

I organized my materials into a text in relation to each of the seven participant nurses as I had excluded the data on the nurse who had to drop out due to illness. In chronological order and by clinic, Meadowview or Brookline, I included observations, interviews, other documentary data, and the audiotape interviews of the four nurse leaders. This chronological ordering of the data provided a starting point for my analysis.

Each observation and audio taped interview was transcribed and then re-checked for clarity, and completeness. After personally transcribing two of the eleven audiotapes, a process which was extremely time consuming; secretarial assistance was obtained to transcribe the remaining nine interviews. Upon receipt of the draft transcripts, I then re-listened to the audiotape with the draft transcript and made changes as necessary, primarily to medical terminology. I returned these to the transcriptionist and she completed the final copy. The documentary sources were re-examined and tagged for later usage. The process of re-visiting these materials provided an opportunity to re-familiarize myself with the materials that I had obtained.

Analysis entailed a thorough line-by-line reading of all of my observational materials and audio taped interviews, beginning with Meadowview and then moving onto

Brookline. During my reading I made notations against anything in the transcripts that appeared to be of interest to explore further. I went back to these notes many times as I cross-checked my initial analysis with the data collected from Brookline and other documentary sources. As patterns emerged in my observational data, I further cross-checked these with the audio taped interviews conducted with both the participant nurses and the nurse leaders. I went back and forth between the observational materials and the interview materials, and in this way I often found myself re-reading the observational materials in a different light. I also went to the organisation's library to obtain additional material, mostly in the form of pamphlets and information that are available for patients.

As patterns of practice emerged, I was able to hold them up against the organizational change initiative and asked where these practices came from, and why they had come to be taken up. I also held them up against the interviews and other documentary data and asked whether the practises that I observed in the day-to-day were accounted for similarly in the interviews. I was able to pick out similarities and differences in the manner in which nurses enacted their practice at Meadowview and Brookline. I also identified similarities and differences in the manner in which the participants and the nurse leaders accounted for practice. In other words, what the participant nurses say they do in practice and what was observed revealed areas of congruency, and also areas of mismatch. I made notes of these differences and similarities and these findings constitute the theoretical position that I advance in the following chapters.

Practice as a site for study

In the first three chapters, drawing on Foucault, Giddens, and Garfinkel, I have explored the terrain in relation to what is seen to both have influenced and been constitutive of oncology nursing practice. A critical read of the discourses of health care re-structuring, re-engineering and re-forming extends the usual discussion of how organizational changes are depicted as benefiting patient care. In the following chapters, I explore how oncology nursing practice proceeds in the face of an organizational change initiative. The intention is to advance an understanding of how the practice of oncology nurses has been impacted [changed] by this initiative. Success or failure of organizational changes is seldom explored at the practice level.

In the following three chapters, a particular critical reading of these research materials will be presented. Narratives of oncology nurses will be strengthened by observations of every-day practice. That is, nurse's talk about their practice will be cross-checked with the observational materials to reveal the areas of similarity and differences. As nurse leaders are often called upon to initiate or implement organizational changes, a read of their perspectives of oncology practice extends the discussion of how oncology practice changes are accounted for. These accounts are contrasted with those of the nurses to explicate the areas of resonance and dissonance. The areas of dissonance are further explored drawing on Foucault's concept of power-relations. The purpose of this paper is to explore and advance the discussion of how nurses proceed with their practice and the knowledge[s] that they draw upon in that production. The following chapters examine how their practice proceeds.

Chapter Six: Getting Organised – Running the Ambulatory Clinics

Good morning to you, Good morning to you
We are all in our places with sun shiny faces
And this is the way we start out each day

Child's rhyme – Author unknown

Introduction

Similar to the children's rhyme above, there are similarities across the study clinics in the way in which the participant nurses "start out each day." In this chapter I describe how the nurses organize their work in relation to the ambulatory clinics. The practises that are routinized within the ambulatory clinics are revealed and the organizing structures that bind these practices are explored. In Chapter Two I indicated that one of the identified purposes of the organisational changes was to "design processes for the efficient linkage and flow of patients through agency facilities" (Cancer Agency, Patient Care Change Report, 1996, p. 3-1). Examining how nurses facilitate the flow of patients reveals how this goal is played out in the day-to-day and what aspects of care are prominent, and those that are in the shadows.

The organisation of work and those practises that are routinized, and those that are not, have an impact on both the nurses and patients/families. Although the practises at both clinics are somewhat different, the organization of care in the ambulatory clinics by the nurses is remarkably similar. Examining the similarities and differences in how nurses' practice in the ambulatory clinics reveals the forces at play that influence the production of day to day practice, and the efforts of nurses to both maintain and challenge the status quo. Specifically this chapter will focus on the practises related to follow-up patients in the ambulatory clinics.

Getting Underway

Reporting in

At both clinics the nurses have a scheduled rotation that is repeated every six weeks. This schedule indicates the days they work, and the time of day that they start their shift. For example, a full time nurse works 36 hours in a week and is entitled to vacation days that are taken at agreed upon times, and according to the union collective agreement. There are also ten earned days off (EDO) that are scheduled into their regular rotation. They work an eight-hour shift with start times that may be at 0800, 0830, 0900, 0930 or 1100. The majority of the nurses start at 0800 and those who are scheduled to start at this time meet together for report.

Report consists of one of the nurses in a leadership position, for instance the manager or nurse in charge, reading out the assignments for the day. The following excerpt is taken from one such report encounter at Brookline. The 5 nurses on duty at 0800, one student, and I all sit in the chemo room. The manager holds a clipboard with the day's schedule and assignments on it and begins to read at 0801.

Manager: Sooo, lets see what's happening today (**looks at the clipboard in her hand**)ⁱⁱⁱ. Marian^{iv} in Pod B with Dr. A, B and C and Cindy will be with you when she comes on at 0900...hmmm looks like 11 follow-up patients and one new one. Okay? (**Looks up at Marian**).

Marian: Nods affirmative.

Manager: Mavis, (student nurse) are you with Marian this morning?

Mavis: Yes until 1130.

Manager: Okay then...Jean and Freda in Pod C with Dr. D, E and F with 12 follow-ups [patients] and one new [patient] at 0945.

ⁱⁱⁱ Actions/observations are bolded.

^{iv} All names are fictitious to protect confidentiality.

Manager: Greta in new patients at 0930 with Dr. G...hmm there seems to be 3 or 4 expected. There is a new patient at 0900 so will you, Jean go do the new patient until Greta arrives.

Jean: Sure.

Manager: Bertha, N1 in chemo and Pat at 1100, with 32 booked. Janice in triage.

Bertha & N1 Do not acknowledge the manager as they are quietly talking together.

Janice: Nods affirmative.

Manager: This afternoon, Jean and Greta in Pod B with Dr. H, I, J with 13 follow up patients, Marian and Mavis in C with Dr. A, B and D and Mary in new patients and Janice in triage. Same three in chemo...any questions?

Nurses: No. Time is 0806, the nurse manager leaves the chemo room.

The nurses begin to chat about an upcoming social event. One nurse begins to put tubings into IV bags in preparation for chemotherapy. The others sit and chat until 0820 and then get up and go to their assigned clinic areas.

This excerpt is a somewhat typical depiction of the activity of report that I observed in both of the study clinics with some variation in the length of time taken and who actually reads out the assignments to the nurses. In none of the report times that I observed were specific patients mentioned, or were any specific references made to patient care. The reports were focused on assigning nurses to particular work areas, covering for sick calls and ensuring that there was some sort of *equitable distribution of staff depending on numbers of patients* [my emphasis]. One difference in Meadowview is that rather than going to their assigned area following report, the majority of the nurses went to coffee together before starting their work assignments. At Meadowview, this appeared to be a time for the nurses to socialize with one another and 'catch up' with each other, as once the clinics started they would not see one another for the rest of the day.

The concern about workload and “equity” is a theme that threads through many of my observations of the nurses. In this example, “equity” is not evident in a direct way; it is suggested indirectly in the way in which the numbers of patients are relayed. There is a significant range in the numbers, 3-4; 12; and 32. The nurses [members] know which numbers represent an equitable division of labour. One of the nurse leaders discussing the reason for report time pointed out that things can change as staff phone in sick. Therefore one of the reasons for report is to change the assignments. “I think people get their noses out of joint if in your clinic you get two nurses and in my clinic I only get one because so-and-so is sick” (NL3, 2001). Thus a purpose of report is to divide the workload in a way that is known to members.

On two occasions when I was present at report time (0800), none of designated nurse leaders were present. The nursing staff looked at the sheet that had their names on it and discussed amongst them how to replace a sick call, and then went to their assigned area of work. The nurses whose start times are later than 0800 go to the nurse’s office and look at the schedule for their assignment. They then go to the assigned area and begin working. The practice of report was mentioned by half of the participant nurses and all of the nurse leaders in the one on one interview that I had with them. I asked the participant nurses and leaders to describe a typical day and how work was organised. Report was a feature of their accounts.

Four of the participant nurses mentioned report as the way in which their workday begins. They describe it as: “a short nursing meeting just to discuss any changes in the assignments and update people,” and “our brief little report, which sometimes gets a little lengthy, but is meant to be just a...an exchange of where people are going and who

needs to be relieved,” and “we all meet at 0800 in our nursing office, have report and then we all go for coffee.” However, another participant nurse states,

When you come to work you know what you’re going to be essentially doing because there isn’t much unpredictability, and patients are on a schedule, nurses and doctors are on a schedule. When I come to work I’m pre-assigned and know what I will be doing that day.

This nurse indicates that the schedule brings order to her workday and she knows what she is going to be doing from day to day, as “there isn’t much unpredictability.” This is a different perspective than the others who speak to the need to check in to see if there have been any changes. This nurse suggests that even within those changes she has a predictable sense of what she will be doing in regards to her assignment.

Although there are different perspectives regarding report, it appears to be a practice that has somehow always been done and one that the nurses take for granted. They did not question the purpose of spending time reviewing the schedule or that only the nurses that start work at 0800 actually participated in this report. They also did not mention that none of the other professionals, physicians, pharmacists, nutritionist and so on, have a report time.

Waiting to be assigned

On the other hand, the nurse leaders interviewed, [referred to as NL with an accompanying number] had several different perspectives regarding the routine of report. In response to asking the nurse leaders what a typical day was like for the nurses, they all mentioned the report time. Following are several comments about the start of the day and in particular the practice of report.

NL2: So they sort of come in and wait for direction.

LS: Okay.

NL2: There's this...somebody needs to organize me. And I was thinking about this, in the inpatient environment, they did the same, which I find interesting that in actual fact you had to, you sat down and you had a report, do we do that here too?

LS: Right.

NL2: Of which, I am struggling to see whether or not there's any great benefit from that, but anyhow, they wait and somebody tells them what to do. And then there is a period of socialization that happens to a certain extent where they will certainly catch up on who's who and what's what.

LS: Uh-Huh.

NL2: Unless somebody hasn't been around for awhile or not often as you know you could use [this] as an opportunity to try to give them a heads up or use it as a communication time, but that report time seems to be quite a popular time for them. Their day, they spend their day in...they don't look at the day as a whole day.

Although NL2 questions the benefit of the report time, she goes on to explicate the potential value in relation to the nurses socializing and also as an opportunity to catch up with each other. Similar to the participant nurses, NL2 does not attempt to explain the discrepancy between the need for report for the 0800 nurses but not seemingly necessary for those nurses that start the work day later.

NL2 refers to the similarity of the cancer clinic report practice to report practice in the inpatient units of a hospital. Inpatient reports referred to as nurses' handovers by Latimer (1993) typically entail a review of the patients who are on a particular ward, their status, and care needs. In the reports at the cancer clinic only the numbers and types of patients are mentioned. Individual care needs are not mentioned in any detail. However, similar to what Latimer (1993) described regarding the implicit references to care "carried in the diagnosis and condition of the patient" the report in the clinics have implicit references to care (p. 114). For example, the nurses are assigned to clinics with particular physicians. The physicians typically care for particular types of oncology

patients such as those suffering from breast cancer, or colon cancer, or lung cancer, and so on. Therefore, when Nurse Marian is assigned to Pod B with Dr. B and C, she is aware of the particular types of patients that she can expect to see in that clinic because of the patients that these physicians typically treat. So, although at report there are not references made to individual patients, the nurses via their assignment are alerted to the types of patients who will be attending the clinics. This prepares them for the potential care needs that they might encounter.

Latimer (1993) suggests that the routine of reporting facilitates surveillance. In report, when one of the leaders assigns the nurses rather than the nurses doing it themselves, the supervisor is able to ascertain that the nurses are present and accounted for, and that they are going about their work in a manner that has been predetermined. This notion is somewhat picked up by the perspective of NL3.

NL3: O.K. um, yeah well like they do seem to have a pretty structured day for the most part. And they start out with their, their morning report, so called morning report during which time they get assigned to different areas of the ambulatory care unit, whether it's chemotherapy or whether it's follow-up.

LS: Right, so there's a schedule and they know where they are in the schedule every morning. So what's that about?

NL3: Well as near as I can tell, it just seems to be a time when all of them can get together and sort of can get their directions. And they do seem to, and I don't know maybe it's because they know they can't make decisions and do their own thing. So they then feel like they don't get a kick-start to their day until they've had permission or been given direction to do whatever it is they they're meant to be doing. And that probably sounds a bit funny but I'm wondering more so now if they have, you know, tried in the past to be creative, tried to adapt and adjust and modify schedules and what not and have encountered various obstacles or blocks? And so then they resort to or regress to umm upholding only the structure. So unless you tell me to do something, I'm not going to do it.

LS: Ok, because I did ask a couple of the nurses, you know if I am nurse A and I'm always in gyne clinic on Monday morning, that's how the schedule looks. How is it that on Monday morning you wouldn't know to go to the gyne clinic? And the only response I received is that things can change, you know people can phone in sick and those types of things.

NL3: Yeah, well and that does happen because of sick time and other things...and it does mean that you know, because of the site team things if you're considered the GI [gastrointestinal] nurse and you've got a GI clinic going on today, um you might be as a senior person say moved to another location because you are viewed to be more adaptable. But then that moves you away from the area that you're familiar with. Or the group of studies and so on and so forth.

LS: So that's not seen as a good thing? Yeah, okay.

NL3: So yeah there are changes and there do seem to be a number on a day-to-day basis, but still they're all written on a page and you know if you can remember what your name is, you look in the morning and you look in the afternoon and you see what part of the building you're to go to and depending on what area of the building you're to go to, which one of the clinics, that too gives you further information about what your day might look like.

LS: Right.

NL3 unlike NL2 does not allude to the value of the report time. NL3 questions the practice and speculates that the nurses may have been rebuffed in the past for attempting to arrange them, so now they wait to be organized by someone outside of their immediate group, someone designated as a nurse leader. She further alludes to the notion that while the nurses accept the practice of having their assignment given to them by one of the designated leaders that they would be quite capable of organising themselves. They however, at present, believe they must wait until someone tells them what their assignment for the day will be. During my observational period, the nurses perpetuate the report practice by their participation.

In her study of ICU (intensive care nurses), Street (1992) suggests that nurses and administrators daily "recreated and maintained hegemony" (p. 217). In particular, Street

indicates that nurses while objecting to certain bureaucratic process [in this case report], continued to act in ways that supported these processes. Therefore, if the nurses were concerned as NL3 suggests that the report somehow undermines their ability to either exercise creativity or flexibility, they did not demonstrate that during my observations nor mention any concern about report during the taped interviews. Rather, they were inclined to mention report as something that just happened every morning, to start off each day, similar to the children's rhyme at the beginning of this chapter. They did not question the practice and as Street indicates, "hegemony is recreated and maintained by unquestioning acceptance of unexamined behaviours and actions" (p. 218).

Hierarchy reversed

The practice of report goes unquestioned by the participant nurses. The nurse leaders, while questioning the practice do not go further and explore how it is that report came be the start of each day, and who is benefiting from this. NL2 believes there may be a social benefit for the nurses and NL3 questions whether passively joining in report is a form of resistance by the nurses based on past grievances. Past grievances are not directly evident, however, report time is an interesting example of the hierarchal nature of the organization. On the surface, the nurse leaders appear to control the report time by assigning the nurses to the various work areas in the clinic. However, the nurses, by awaiting direction from the leaders in effect direct the nurse leader to be present at report. This form of resistance, although not immediately apparent, indeed positions the nurses themselves as controlling the work of the leader in the accomplishment of report. Thus, they play on the hierarchy, knowing that the leader will respond to the apparent need to direct the work.

The nurse leaders may also benefit from the report as it facilitates active surveillance of who is present and what they will be doing. The practice of report somehow signifies a legitimate activity for the nurses and one that sets the stage for legitimizing the series of other activities that they are assigned to, for example the chemo room, or the ambulatory clinic. In the ambulatory clinics their assignments fit into the organizational structure of the physician schedule. They are assigned to a clinic area and the physicians in that area rather than being assigned to particular patients. The assignments coming out of report form the structure for the day and set the stage for the routines of the clinic, and chemo rooms.

Setting Up for Care: Ambulatory Clinics

Meadowview

Meadowview is a modern, low profile two-story building adjacent to an acute care hospital. Aesthetically it is quite pleasing with large windows, an inner courtyard, and the walls are adorned with quite lovely artwork and some beautiful quilts. All of the wall decorations have been donated and there are little plaques on all of these indicating the names of the people who have donated them. Many of the plaques indicate that they have been donated in the name of someone who apparently was a patient at the clinic. Patients check into the main desk at the entrance and if they are to be seen in the ambulatory clinics they are directed by the clerk to the clinic area where their appointment is to occur. If they are coming for chemotherapy they go directly to the chemo treatment room.

There are scheduled ambulatory clinics in the morning from approximately 0845-1200 and in the afternoon from 1300-1600. In the ambulatory clinics (A, B & C), there is

a horseshoe shaped reception desk where the clerk works. In front of this is the patient waiting area. Behind this is the staff work room and the individual exams rooms on each side.

The patient charts for each clinic are organised on a trolley beside the workroom, in the order of how the patients are meant to arrive according to their appointment time. There are 3 chart slots or hangers on the outside wall of the workroom marked with the name of the doctors who are in the clinic that particular morning or afternoon. There is a patient appointment list taped to the chart wall hanger with the list of patients for each physician for that particular morning or afternoon. The patients who have been seen previously are referred to as follow up patients and are scheduled for a twenty-minute appointment. New patients are scheduled for one to one and a half hours.

Patients check in at the desk, speak to the clerk and put a card in a little tray on the top of the desk and then take a seat in the waiting area. The card is the same size as an old-fashioned cardboard library card. The patient is given the card at their first appointment at the cancer clinic. They are requested to bring it with them to each and every visit to the clinic. The card has the patient's name and identification number on it and the date and time of their appointment. Putting the card in the tray signals that the patient has arrived and the nurses check the tray frequently to determine which of the patients listed on the patient list have arrived.

At the beginning of each appointment with the physician or treatment, chemotherapy or radiation, the card is presented and at the end the card is given back with the next appointment date and time printed or stamped on it by the clerk. There appears to be little if any negotiation regarding appointment dates or times. According to

the nurses in clinic one, the “cards help us keep track of who is here and who isn’t.” (Observational Notes, 2000). At Meadowview the patient waiting area is in front of the reception desk area and therefore the patients are visible, and can be monitored by the doctors, nurses and clerks that work in that area.

In each of the ambulatory clinics there is a schedule for patient appointments assigned by physician. Typically there are two nurses working in each clinic area with 3 or more physicians. The nurses decide which patients they will see. At Meadowview the nurses tended to determine ahead of time with each other how they will work together. For example, they might decide that they will each work with one of the physicians exclusively and both assist with the 3rd physician’s patients. Or, they might take one at a time, with a first come first serve approach. In the observational materials there was a concerted effort to divide up the new patients amongst the nurses due to the amount of time that these patients require. This is another example of how ‘equity in workload’ is constructed.

Passing the baton [patient]

There are systems of signification that have been set up at both of the clinics to signal the steps in what might be described as the patient relay. Latimer (1993) suggests that these systems are a “combination of a material practice and routines that help signal that a particular set of activities is about to occur and in which ways they are to occur” (p. 125). The first step is when patients come for a follow-up visit and put their card into the tray signalling their arrival. The clerk looks at the cards and puts the patient’s chart in the specific physician chart slot. A chart in the slot signals to the physician that the patient has arrived. At Meadowview, the nurse looks at the cards that are in the tray and finds

the cards [patients] that are scheduled to see the physician that she/he is meant to be working with. When she sees one, she goes to the chart slot and takes the chart out to review the previous visit notes. The nurses often shared with me their thoughts about what they thought about the patients by looking at their chart. For example, N4 reviews a new patient chart, "hmm, this [the patient] is likely going to be okay, he likely has lymphocytic leukemia, but chronic, so he should be okay." Also N7, "this patient has mets [metastases] and last time she was here, she was really sick." The nurses anticipate the patients' needs by drawing on the information in the chart, their knowledge of oncology, and in the case of N7 her recollection of the patient from a previous visit.

After a brief review of the chart, the nurse calls the patient from the waiting room and escorts them to an examination room. She takes the chart with her. When she is finished with the patient, she leaves the room and writes the room number beside the patients name on the patient list and puts the chart back in the physician slot. Both of these actions signal to the physician that the patient has arrived, is in an examination room, and has been seen by the nurse. The nurse then gives report to the physician that entails a verbal rendition of what the patient has told the nurse and also whether the patient's weight was up or down. Occasionally the physician asks a question, but usually just listens while examining the patient's chart to refresh his/her memory regarding previous events.

The physician then goes to the examination room and presumably interacts/examines the patient [the nurses and I were never present during this part of the visit]. The physician comes out of the examination room, dictates a note, and hands the chart to the clerk to process any orders that he/she may have written. When the patient

leaves the examination room, the clerk hands them back their card with their next appointment date and time on it. The patient is also given any requisitions for tests that need to be done before the next appointment. The patient leaves and may or may not see or speak to the nurse prior to their departure. At Meadowview, if the nurses are busy with patients, the physicians will also take the charts from the chart slot, call the patient from the waiting room, take the patient to the exam room, examine the patient and the patient will leave without the nurse ever having seen them.

Brookline

The relay routine played out at Brookline has some subtle differences. The nurses tend to work more loosely with specific physicians though they will self-identify with a group of patients, for instance gyne patients [women with gynaecological cancers]. At Brookline the patients also put their cards in a tray and then go to a large waiting room that is shared with all of the ambulatory clinics. The clerk then takes the patient's chart and puts it on a trolley outside of the nurse/physician workroom. Placement of the chart on the trolley, *signals* to the nurse that the patient has arrived.

Similar to Meadowview, the nurse gives the chart a cursory look and then goes to the main waiting area, calls for the patient, and escorts the patient to an examine room. Once the nurse is finished with the patient, she returns to the workroom, writes the patients name, room number, and physician name on the white board. This signals to the physician that the patient has arrived, has been seen by the nurse, and the number of the exam room that the patient is in. The nurse puts the chart on the counter where the physician can find it and once he/she has the chart, the nurse gives a brief report to the physician. The physician goes to the exam room and presumably examines the patient.

At the end of the appointment the chart is given to the clerk to process any orders, fill out lab requisitions, and set up the next appointment. The appointment is written on the patient's card, which is returned to him/her before they leave.

Although the practices at the two clinics are somewhat different, the underlying organizing structures are remarkably similar. As previously discussed, Munro (1999) suggests that routines are never fixed. He goes on to indicate that individuals are participants in creating their routines and that these routines are not simply the result of "fixed structures such as culture, class, gender and race" (p. 431). Latimer (1993) suggests that "routines represent not just the ways in which nurses manage both patients and nurses, in terms of resources, time and space, routines accomplish aspects which help reproduce and maintain a particular order of things, and a particular disciplined space" (p. 127). Latimer further suggests that routines and materiality assist nurses to know what to do for patients. How the routine(s) of the ambulatory clinic enables nurses to know how to care for patients with cancer will now be discussed.

Routine Care for Follow-up Patients

Organizing structures

A critical review of the ambulatory clinic routines reveal a series of actions that nurses participate in or construct that provide a structure for care. Beginning with morning report, a typical day as articulated by the nurses would appear to follow a somewhat predictable series of events. The report, however appears to have nothing to do with the care of patients as they are not mentioned, nor are care issues or problems brought up. It is an opportunity for the nurses to check in and see who is present and who isn't and to find out what everyone will be doing for the day. Report also occupies the

time of one of the nurse leaders who is positioned by the routine to tell the nurses what their assignment is. None of the nurses questioned the value of the report, nor the contradiction that nurses whose start times are later than 0800, simply read the schedule to find out their assignment.

The contradiction of waiting to be assigned indicates a form of resistance and shift in power relations on the part of those nurses who continue to participate passively while their assignments are read out to them. Although the participant nurses did not acknowledge the notion of resistance, one of the nurse leaders speculated that their passivity might be a result of past rebukes when they tried to take more control of their day. Regardless of the reasons, the nurses are resisting the power of the nurse leaders by awaiting direction before proceeding with their workday. They are impervious or choose to ignore the inconsistency of their actions and similar to Street's (1992) observations, their resistance "results from an analysis of a situation and a decision to act in a manner that is more liberating for the individuals themselves or for others" (p. 225). It is difficult to ascertain, and nor did I explore with the nurses, the contradiction in how they describe themselves as experts, but fall back to a passive stance when it comes to organizing themselves in the clinics.

The physician schedule is the focal point for organizing their day. It is within the structure of this schedule that nurses have created their patient care routines. New patients are allocated 1 to 1.5 hours and follow up patients are allocated 15-20 minutes per visit. The designation of patients as follow-up or new, how much time s/he will have with a patient signals to the nurse which type of routine care is called for. Care is also

routinized and proceduralized based on the particular tumour type or diagnosis that the patient has.

New patient routines are structured around the information that is gathered from a health assessment form that the patient fills out upon their arrival at the clinic. Also, information is gathered from the chart, for example the pathology reports from surgery, previous diagnostic, and lab tests. Information about follow up patients is similarly housed in the chart. Nurses may have some additional knowledge about individual follow-up patients based on previous encounters, and they share this knowledge with each other as time and opportunity permits. However, documentation of this information by nurses is not consistent and is not comprehensive. So an opportunity to share information and the special nursing knowledge associated with caring for these particular oncology patients from visit-to-visit is often lost.

The patient's personal identification card signifies to both the clerk and nurse that the patient is present for their appointment and waiting to be seen. The chart trolley, the chart slot, the white board with patient names and room numbers, all signify to the nurse and to some extent the physician that particular events have occurred, and that it is time for another event to occur. For example, when a physician sees a patient's name on the white board with a room number beside it and a physician name, he/she knows that the patient is in room [number], has been seen by the nurse and is ready to be seen by the physician. The physician also knows that the nurse will have some current information about the patient that he/she may need to know before interacting with that patient.

Disciplining patients

Follow-up patients are also disciplined to these routines. They know that once their card is in the slot that they can expect to be seen by a nurse and taken into one of the examination rooms. From the observational material, many patients were observed in the exam room to immediately go to the scales, as being weighed is a routine part of the nurse's encounter with the patient. Also many of the patients kept written records of their symptoms post treatments as they expect to be asked "how have you been since your last treatment" and they came prepared to answer that question.

New patients and those on their first follow up visit are not immediately aware of the routines but as the number of their visits increases they soon too fall into the routine patterns of the clinics. They are reminded to bring their identification card with them and are also told that if they call into the clinic, they should use their identification number. Disciplining patients to refer to themselves by their number is a powerful example of how the routines of the clinic render individual patients invisible. The individual patient is sacrificed to the routines of the clinic and patient needs or concerns that fall outside of the prescribed routines are seen to disrupt the flow of the clinic as they throw the schedule off.

Several of the participant nurses described a "terrible day" as one "when people [do] not get the right appointment date and they're coming at the wrong time or on the wrong date and we have to fit them in" (N5, 2000). Contrast this with N4 who describes a good day as "when you've been in clinic or in the chemo room and it's running on time". In other words, the routines of the clinic based on the schedule necessitate a flow that is not disrupted by unexpected events such as an unannounced patient. Additionally,

the nurses have taken up the organizational value of keeping to the schedule. Further discussion regarding how it is that nurses have come to take up the routines of the clinic and the possible benefits that occur as a result of routinizing care.

Time, Space and the Schedule

Routinization as control

Street (1992) indicates that nurses contribute to their own hegemony due to thwarted attempts at resistance and thus resort to “yes but” language when suggestions are made to possibly improve those practices that are identified as not benefiting patients or nurses (p. 217). I suggest that routinization of care has a more complex underpinning than simply the inability of the nurses to resist the hegemony of how the ambulatory clinics operate. Giddens (1984) describes routinization as “the habitual, taken-for-granted character of the vast bulk of the activities of day-to-day social life; the prevalence of familiar styles and forms of conduct, both supporting and supported by a sense of ontological security” (p. 376). The idea that control of the day-to-day through the mechanism of routines contributes to a feeling of security resonates with my observations and interviews in the ambulatory clinics. The nurses when describing a typical day in the ambulatory clinic seem unaware that their descriptions portray multiple routines in a taken-for-granted manner that implies that the way things are done are self-evident and require no explanation. For example, the following excerpt describes the organizing structure that is attributed to the schedule.

N5: When you come on to the day you know what your day is going to be essentially because there’s not as much unpredictability as on a, on a hospital job.

LS: OK

N5: You know where you sort of, everything is very controlled, you've got a lot of supports on shift. So that's quite different, I think you know, coming from ward nursing into ambulatory care. And patients are on a schedule, nurses and doctors are on a schedule. And you try and sort of keep to that to make everybody happy whereas when you're on a ward it's the nurses are sort of in control, the boss.

LS: Uh, huh

N5: Its true, I mean it's interesting but it is true. But when I come to work here, I am pre-assigned, and one of the reasons that it works so well here is that um, we're trying to have *consistency for the patients* [my emphasis].

In this example, the schedule is reified as the control mechanism for the nurses, physicians and patients. The scheduling of all three contributes to a predictability of events. Further, the implication in this excerpt is that adhering to the schedule keeps everyone "happy" or following Giddens, contributes to ontological security.

Interestingly, N5 also implies that the schedule benefits the patient by providing a mechanism to ensure "consistency of care". I suggest that attributing benefit to patients is an attempt to legitimize the routinization of care based on a fairly rigid schedule that supposedly makes everyone happy as long as it is adhered to. In my observational materials, there were numerous occasions where patients did not adhere to their allotted time, which disrupted the smooth flow of the clinics. In many of these cases time was either made up with other patients or the clinics ran late.

One of the recommendations of the re-engineering organizational change was to "develop a new scheduling system compatible with the patient care model" (Cancer Agency, Patient Care Change Report, 1996, p. 2-11). The schedule was intended to be flexible, reduce patient wait times, and facilitate consistency in care by providing patients' access to their primary oncology nurse throughout their care at the cancer clinic.

It was apparent throughout my observational time that the schedules were somewhat rigid and although consistency of physician appeared to have been achieved, nurses were scheduled to best fit patient workloads rather than individual patients. As mentioned previously, one of the purposes of morning report was to re-assign nurses from their regular clinic responsibilities to another clinic to either replace a nurse who was sick or to equitably balance the workload between clinics and nurses.

Hierarchy

Giddens (1987) suggests that timetables [schedules] are “time-space organizing devices” and as such serve to co-ordinate the activities of large groups of individuals (p. 160). Giddens goes on to describe the various hierarchal power relations in organizations that are played out in the name of timetabling. For example, he suggests that those in higher-level positions have timetables, schedules or time texts, that have very little interaction with other people’s timetables and provide individuals with a level of autonomy over their personal time. Whereas those lower down in an organization are scheduled according to the needs of the organization with little if any autonomous time. As previously discussed, this might explain why the nurses at morning report ‘wait’ to be assigned by a nurse leader as it plays into the hierarchical structure of the cancer organisation.

Following Giddens, schedules in the ambulatory clinics reveal the positional dominance of the physicians over both the nursing staff and the patients. The physicians’ schedules are comprised of computerized lists of patients categorized by time and designated as FUP, NP, or CV (follow up patient, new patient or consultation visit). Outside of the ambulatory clinic schedule, physicians may also be scheduled for

treatment times. There are also periods throughout the week which are undesignated times. This so-called office time is not visibly accounted for in relation to the rest of the cancer clinic operations and organization. What goes on during this time appears to be between individual physicians and their leader. Time spent away from clinic operations is not questioned by others, and when asked what the physicians do in their offices, the typical response was “research.”

On the other hand, the nurses' schedules are, following Giddens (1987) “wholly convergent with, and determined by, the timetable of the organization” (p. 161). Their time is accounted for on the master-nursing schedule, which coincides with either ambulatory clinic appointments or assignments in the chemotherapy or radiation therapy areas. In the ambulatory clinic area, the nurses do not appear on the schedule beside the patient names. Their work is based on the patient lists for the physicians. Nurses' time with patients therefore is dependent and contingent upon the physician's time. Further, the time that nurses spend with patients is bounded by the amount of time each of the categories of patient were allocated, for example 20 minutes for a FUP and the amount of time that the nurse expected the physician to take. One of the few times that nurses could control was those times in the master schedule designated as office time.

In the re-structuring process it was identified that each of the PON would require 0.5-1.0 days of time that was not scheduled to a specific clinic to make telephone calls, assess care paths, organize upcoming clinics, review patient data, and liaise with others involved in the patient's care within the centre and in the community (p. 8.1-13). This “office time” also provided nurses with an opportunity to work on professional development activities such as committee work, preparation of presentations or

publications. At the time of my observations, although office time was still part of the schedule, often nurses were re-assigned to one of the other areas of the clinic operations to fill staff sick vacancies or workload obligations and thus their office time was taken away from them. This is yet another example where regular assignments gave way to the need for equitable workload. In contrast to the invisibility of the office time of the physicians, the nurses were called to account for their time and nurses office time was a fairly frequent topic of conversation both in formal and informal venues. Questions were asked by physicians and leaders regarding what they were doing during office time and whether or not according to one leader that “there was value added” to the organization (NL2, 2000).

In relation to the construction of a hierarchy, the patients are also lower down in the hierarchy. Their time is accounted for according to the time-space organizing device of the schedule. Although the intention of the re-structuring was to implement a flexible schedule, there are standard times set for new patients [one hour] and follow-up patients [20 minutes]. Patients came to know not only their allotted schedule time, but also the accompanying wait times, and intervals between ambulatory visits.

Patients were observed to ask “how far behind is the clinic today” or “has Dr Jones arrived yet” or “how far behind is Dr. Smith today” (Observational notes, 2000). N6 describes the patients as “pretty long suffering and fairly used to it” when asked how the patients reacted when their appointments were delayed. I also observed patients re-book their appointments rather than wait for excessive periods of time. Clerks told me that certain physicians’ patients phone in prior to their appointment time to enquire about the length of the wait, and thereby alter their own arrival time to coincide with when they

are likely to be seen rather than when their scheduled appointment time is. These patients had found a way around the computer schedule that better fit the actual clinic functioning which, in the case of several physicians, was always approximately 30-45 minutes late each and every clinic day. The clerks providing these patients with this information are also working around the approved schedule. Likewise, nurses also worked outside of the schedule.

Working outside of the schedule

The routinization of care has the effect of reducing patients to small manageable pieces and efficiently moving patients through the system. The schedule, with patient categories and time slots facilitates the smooth flow of clinic operations but does not account for individual differences in patient needs. An uncritical view of the scheduling process in the ambulatory clinics positions the nurses as passive recipients of a timetable that accounts for their time in ways that are beyond their control. Rodney & Varcoe (2001) suggest that the absence of written scheduled nursing time contributes to the lack of control and to the invisibility of nurses' work. However, Munro (1999) suggests that actions are not necessarily predetermined "things can always turn out differently" (p. 431). Indeed my observational materials suggest that at times nurses did demonstrate the ability to take control of their time with patients in spite of the schedule. The following field notes are one example of taking control.

0905: N1 escorts patient B from the waiting room to exam room 8. As I enter the room B is sitting on a chair adjacent to the exam table. She is approximately 35 years old and her face looks sad.

N1: How are you? (N1 is standing).

B: Dragging, I was diagnosed in 1996 and then found out that it had spread in September, so I am having radiation...I am feeling nauseous...

N1: How is your skin?

B: Fine.

N1: Anything else?

B: I am uncomfortable. I have a dull ache right here (**points to her left flank**) and... actually I am not managing (**lowers her head and starts to cry**).

N1: **Pulls up a chair beside B, gives her a Kleenex and pats her on the shoulder.**

B: **Continues to sob quietly, then very quietly,** my job is sucking the life out of me.

N1: Oh dear, that is not a good thing **and continues to pat B on the shoulder.**

B: **Crying softly:** I need help, I don't want them to know at work that I have cancer, that will only make things worse, but I have to work, I have no money. I almost cancelled my appointment here today.

N1: Well I am glad that you decided to come... it sounds as if you need to figure some things out and we can help you with that.

B: **Stops crying.** I just don't know if I can carry on.... I don't think that I am whining...I think I am having a meltdown...**begins to cry harder.**

N1: No, I don't think you are whining... it sounds as if things are becoming more difficult for you and we can help you sort some things out.

B: On top of everything else, this beast within me might be growing. I am stoned at work all of the time as that is the only way I can get through the day...**unable to discern next part of the dialogue as B is crying very hard and N1 is talking softly to her.**

N1: I am going to go out for a minute and call the social worker to come over and chat with you. They can help you with some of these concerns and give you some ideas about how to manage at work, and finances, and all sorts of things. Is that okay?

B: Sure, I feel ready to explode.

0936: **We leave the room and N1 puts a call in to the social worker and informs the physician who has been waiting to see the patient the**

concerns that the patient has expressed, and then goes back in the room to stay with the patient until the social worker arrives. The entire elapsed time that the nurse spent with the patient was approximately 35 minutes.

In this situation N1 chose to stay with the patient for the length of time it took to get someone to assist her. She did not appear rushed, nor did she appear eager to hurry the patient through her meltdown! Interestingly, the other nurse in the clinic and the physicians did not appear to be disconcerted by the time that she took with this patient, nor were other patients delayed due to this situation. The physicians and nurses accepted her explanation when she came out of the exam room of what she was doing and did not question either the time or approach she had taken. During the period of time that we were in the room, which was approximately 8 times longer than usual for a follow up patient, there were no interruptions from staff wondering what was taking so long. The clinic seemed to be running smoothly when we came out of the exam room and the other nurse and the three physicians did not appear rushed or hurried, and did not comment about having had to do double duty while we were with patient B.

Following the schedule

In contrast to the previous situation, I observed many encounters where patients appeared to be 'put through their paces' in a very quick manner in order to move them through the system. For example, according to my observational notes, the average nurse patient interaction for follow up patients was 4-5 minutes. During this period of time, patients were weighed, asked how they were doing, and often instructed to change into a gown in preparation for the physician exam. If a patient indicated that they were having difficulty with particular symptoms, the nurses promised that they would pass that information on to the physician and encouraged the patient to do the same. Passing on

information to the physician was so the patient would receive some sort of action that would result in the alleviation of their symptoms. Following, is an encounter between a nurse and a follow-up patient that typifies the most common type of encounter that I observed.

0940: N2 escorts patient D (female who appears to be in her mid 40's) and a gentleman into room 7. D sits on the exam table; the gentleman takes a chair in the corner and proceeds to read a newspaper.

N2: Standing beside D – How are you today?

D: Depressed, but I read that is normal?

N2: Yes you are right, it often happens, how are you managing that? Let's see how much you weigh and gestures to the scales.

D: Gets off the exam table and walks to the scale. I am trying to stay active, playing tennis and I take Ativan [a prescription relaxant] to sleep.

N2: Looking at the chart: Hmm your weight is the same, any test results to be discussed today?

D: Blood work and a scan.

N2: Anything I can do to help, there are counsellors available if you need anyone to talk to you just need to phone. Walks towards the door.

D: Nods her head.

0944: N2 leaves the exam room.

In this encounter, although the patient indicates that she is depressed, N2 is focused on weighing the patient and ensuring that the appropriate test results are in the chart, supposedly so that the physician can discuss the results with the patient. Several of the participant nurses indicated during their interviews that they often felt that they needed more time with patients and indicated that they were unable to provide the level of support that they believed that the follow up patients required from them. In contrast to

their claims regarding the need for more time, my observations did not support that they 'took the time' as did the previous nurse. Rather, the goal of the nurse in the ambulatory clinics appeared focused on ensuring that the follow up patients were processed in a timely manner. This goal is congruent with one of the features of the organizational restructuring vision of patient care services that are "well planned, integrated, efficient and responsive" (Patient Care Change Report, 1996, p. 2-3).

NL1 commenting on the nurse's attitude towards the schedule suggests,

They see themselves in this little box. The clinics are set, and they have to get all those patients through, and they [patients] do have to see the doctor. They are there to see the doctor.

NL1 suggests by her comments that the nurses do not feel that they are expected to move the patients through and that the patients are after all at the clinic to see the physician.

She goes on to give an example where she believes that the nurses are more empowered to be flexible in the schedule and when asked why that was, she indicates it is because they "are not under the microscope so much by everybody and they seem to have more independent practice. And I don't know why that is" (NL1, 2000).

I suggest that the nurses that she is describing, practice in the radiation treatment setting that tends to be more geographically decentralized than the clinics. The location of the treatment areas are set up in such a way that surveillance of individual health care providers by others is minimized. Additionally, there are only a few nurses who work in that area and they are very often on their own, so there is very little monitoring of their actions by other nurses. I suggest that the limited surveillance and disciplining by others provides nurses with the space to practice in a way that does not seem possible in the ambulatory clinics.

Visibility

The running of the clinics appears to be focused on efficiency and facilitating the processing of patients. The nurses have developed the ability to fit into the schedule and unless questioned appear to find the care they provide as unproblematic. Those who 'took the time' did not appear negatively sanctioned by others, but perhaps that is more related to the infrequency of the occasion than the acceptance of stepping outside of the schedule.

By adhering to the schedule the nurses are able to make visible their role in keeping the clinics running. The visibility of the practice of putting patients in a room, weighing the patients, and a brief check for problems provides the nurses in the clinics with a role that the physicians apparently accept. The fulfillment of following the schedule by the nurse engages the role of the physician. This is important as the clinics are set up in order for the physician to see patients. I suggest that the role of the nurse in the clinics is more tenuous and the routinization of the work engages the physicians. Although there were a couple of occasions where physicians at Meadowview put their own patients in rooms, by and large the physicians waited for the nurses to accomplish this particular part of the visit. Therefore, it may not be in the best interest of the nurses to step outside of the schedule too often or to be seen to be disruptive to the organizational process if their goal is to maintain their current role.

Latimer (1993) suggests that routines facilitate surveillance and that it is difficult to "step out" when ones' actions are being monitored. In the ambulatory setting the work of the nurses is monitored by the physicians and to some extent the patients, as the nurses' actions facilitate the patients being seen by the physician. Monitoring the

timeliness of the clinics by supervisors and physicians alike adds additional pressure to conform to the schedule. Nurses in the clinics feel pressure to maintain the routines by physicians, supervisors and patients. In turn they pressure each other to conform to the way things are done. They do not question the clinic routines and only when probed do they allude to the need for more time with the patients. However, my materials also suggest that in this setting stepping out is not problematic as illustrated by the interaction of N1. Therefore, there is space for members to exercise discretion with the schedule although they do not talk about this in their day-to-day accounts of practice.

Summary

Street (1992) suggests that conformity occurs due to the oppressive nature of the organizations in which nurses do their work, as it is easier to go along than to resist. I suggest, following Munro (1999) that the nurses make choices where and when to take action that positions them outside of the expected behaviours. In going along with the schedule for follow up patients, nurses maintain their membership with their physician colleagues and uphold the organizational value placed on efficiency. By doing so, they are active participants in pushing into the background several of the other recommendations of the re-engineering project, specifically those related to the development of a collaborative practice approach and clearly delineated responsibilities and accountabilities of the so called patient care team. In the next chapter I will explore the nature of the working relationship between nurses and physicians and reflect on how practice proceeds in relation to the changes anticipated by the organizational re-design.

Chapter Seven: Working Together

- N4 [Speaking to a new patient] You may be wondering why it is that we ask all of these questions. We work as a team here and as the nurse I take a *holistic approach* to you that means I am concerned about all aspects of you, like your family, your occupation [my emphasis]. The doctor is more concerned with treatment and that doesn't mean that he isn't interested in the rest. It is just that his focus is different. There is a team of folks that are here to help you and it is *my job to figure out with you* when it might best be okay to pull in some of them and also particularly on this first visit to make sure that your questions are answered [my emphasis].
(Observational materials - January 4, 2001).

Introduction

As previously discussed the re-design of the patient care team was one of the focuses of the re-engineering organizational change undertaken by the cancer agency in 1996. The model of patient care recommended consisted of three levels. These included the Provincial Tumour Group, the Cancer Centre Tumour Site Teams and a Patient Care Team directly involved in individual care. The Patient Care Team is the aspect of the proposed model that is of primary interest in this study. The re-design process set up expectations for a change in caregiver roles in the name of meeting patient needs with compassion and respect. In particular the role of the nurse was identified as crucial to the successful implementation of the recommendations. The new Primary Oncology Nurse (PON) role was visualized as the caregiver who would "be a consistent link in the patient's care throughout their cancer experience" (Patient Care Change Report, 1996, p. 8.1-4). The minimalist rationality inherent in this vision set up for nurses that somehow the conditions would exist in the restructuring that would facilitate their ability to provide a "holistic approach" to patients. This vision is incongruent with the enactment of the efficient running of the ambulatory clinics depicted in Chapter Six. In this chapter the

discourse of team envisioned in the re-design process is briefly discussed and held up against the day-to-day practices in the cancer ambulatory clinics.

Pivotal to the vision of the team was the relationship and so called collaborative practice that nurses and physicians were intended to engage in. Since 1967 when Stein described the relationships between physicians and nurses and coined the phrase “doctor-nurse game” many have studied and elaborated on how it is that nurses find ways to work with physicians (Chinn, 1985; Pippy 2001). How nurses work with physicians in the ambulatory clinics is explored here against the backdrop of the intentions of the organizational re-structuring. The relationship and influence of physicians on nurses and nurses on physicians will be discussed in the context of the impact this has on how care is delivered to patients. How patients are positioned within this team is also discussed as the relationship between nurses and physicians influences their place in the hierarchy in the cancer clinics.

Patient Care Idealized

Patient care aims

One of the major foci of the 1996 re-design process was to improve the care to patients through the restructuring of the patient care processes. An extensive review of many of the treatment/care areas was undertaken. This included a review of the scheduling and information systems, diagnostic services, ambulatory clinics, chemotherapy, and radiation patient care processes. There was a standardized review format and an external consulting firm facilitated the review and planning process. Over a period of approximately 14 weeks, the Patient Care Change Team met, gathered

information, made site visits to other oncology centres, analyzed data, and mapped out a vision for the future of patient care at the cancer clinics.

The following statements summarize the vision for the redesigned patient care processes.

1. The *specific needs* of each patient are recognized and addressed with compassion and respect [my emphasis].
2. Care provision is *consistent*, appropriate and timely [my emphasis].
3. Patient care services are well planned, integrated, efficient and responsive to innovation.
4. Care providers' roles are well defined, integrated, appropriate to their level of training, and developed to their fullest potential.
5. Communication and collaboration between and within the clinics and with partners in the community is excellent. (p. 2-3).

The intention was to implement a model of care that encompassed the key ideas stated above with the anticipation that there would be tangible benefits for patients in the name of consistent and timely service, and for the organization in the name of efficiency. As illustrated in the previous chapter, “consistent care” seems to have given way to the quest for efficiency and the smooth flow of the ambulatory clinics.

The concept of “specific needs” of each patient was framed in several ways. A flexible scheduling system was to be implemented that would take into consideration that as individuals, patients require differing time allocations for their appointments. As the “consistent link” for the patient, the nurse was positioned as the care giver that would, in conjunction with the patient, identify what these specific needs are and “pull in some of them,” [other team member, to meet these needs.

Another key feature of the re-structuring changes was development of the roles of each of the care providers. I will now discuss how the role of the team consisting of the nurse and physician was visualised, and how this conceptualisation was implemented at

each of the clinics. This will include an exploration of how the roles are talked about and how they are enacted in the ambulatory clinics.

Visions of a Patient Care Team

Partnerships and reduced duplication

The patient care team described in the re-design recommendations for ambulatory clinics include a primary oncologist, a PON, a secretary, and a patient information coordinator. Although the focus of each of these roles was different, the key element in their functioning was the concept that they would work in partnership to benefit the patients. The roles and responsibilities of each of the team members outlined in the re-design documents indicate that the roles were designed to complement one another without overlaps or “unnecessary duplication of care” (p. 8.1-4). This theme of efficiency through the guise of quality patient care is apparent in the practises in the clinic discussed in the preceding chapter. However, what was also featured in those accounts were overlaps that were encouraged, for example, the nurses encouraging patients to relay their symptoms to the physician after promising that they too will relay the same information.

The development of care maps was one of the strategies suggested in the re-design recommendations to ensure that there was no unnecessary duplication by professionals. Under the section of the report entitled Business Case Cost/Benefit Analysis, the perceived benefits to developing care maps, based on tumour group guidelines, were identified. These include,

- [To ensure] that consistent data are captured and are available for evaluation and monitoring of effectiveness of care services;

- [and also] The use of the patient data to modify care maps will enable evidence based continuous quality improvement to occur, and may lead to improved survival and *quality of life* for patients [my emphasis],
- [and] to enhanced safety with compliance to technical and operational standards and guidelines (p. 10-1).

It is interesting to note that the benefits emphasized have more to do with examining the services provided than on the individual benefit to patients. As discussed in Chapter Four, the consensus required for the development of care maps necessitates some form of knowledge exclusion. In this case the patients' knowledge in terms of quality of life is not contemplated in the care map development. The care maps are more about standardizing care and moving patients through the system as though patients with cancer do not have unique features that make this process problematic.

The schedule

In Chapter Six I describe the "relay" of patients in the ambulatory clinics and how it is that they are typically moved through the system. During my observational period, it was not apparent that the recommended patient information coordinator position actually existed in the ambulatory clinics, and I was unable to ascertain if that role had ever been implemented. The original intent of that position was to work with the oncologist and PON to "coordinate patient visits, to ensure adequate times for visits, and to co-ordinate other health professional appointments" (p. 8.1-5). All of these original functions appear to have been designed to meet the competing aims of patient care needs, and also the smooth functioning of the clinic. It appears that some of these functions were taken up by clerk in each of the clinics, but primarily consisted of arranging appointments and tests for the patients.

However, from the observational materials the schedule is not flexible and adequate time appears only to occur if nurses take the time in particular situations outside of the fixed schedule. The original concept that patients, as individuals, require different appointment lengths to address their different needs has given way to categorizing patients by type of visit. The visit categories are allocated a standard time. The clerk in the ambulatory clinics is not assigned to a particular team, but is assigned to a particular clinic setting on a bi-daily basis. For example, a clerk might be in Clinic A in the morning on Monday, Clinic B in the afternoon and on the main reception desk on Tuesday morning. Therefore, it is difficult, if not impossible, for the clerks to consider themselves part of a team when they actually appear to support many different teams.

Likewise, the secretarial position was envisioned to support two of the patient care teams. Most importantly, this position was intended to be the “consistent link for the patient to access the other members of the patient care team” (Patient Care Change Report, p. 8.1- 5). The clerk or secretarial position was described as being necessary to assist in keeping members of the team [nurses and physicians] up to date on requests from patients. It appears that the secretarial positions were not implemented as originally described and the nurses appeared expected to make do with any assistance they could garner from secretaries designated to others. This meant that requests or questions from patients were often stacked up on an answering machine awaiting a call back from the nurse.

The oncologists have secretaries assigned to them although many are shared between two oncologists. I did not have an opportunity to either observe or query their role. The nurses did not appear to have access to secretarial support outside of the clinic

settings except if they had committee work and then one of the administrative secretaries or the secretary for nursing professional practice would assist them.

Role of the nurse and physician

At the beginning of this chapter, N4 describes to a new patient the role of the nurse and the role of the physician. She indicates that the nurse is interested in the totality of the patient and that the physician is primarily interested in the treatment. The other care providers are described as being “pulled in” when the patient and the nurse deem it necessary. N4 goes on to assure the patient that she is there to make sure that any questions that she might have will be answered on the first visit. This particular feature of the PON is similar to the description given for the Information Coordinator as they were also intended to ensure that patient questions were answered. I was not able to ascertain if this constituted an area of ‘overlap’ or if the nurses picked up this function in the absence of the co-ordinator role.

N4’s description is very similar to how the role of the PON is described in the re-design documentation. The PON is not only intended to be the consistent link in the patient’s care, he/she was also intended to facilitate and coordinate the introduction of the patient to other caregivers in the other departments. For example, if a patient was to undergo radiation treatments, the PON would meet the patient on their first visit to the radiation department and introduce them to the radiation treatment team. The nurse would apparently keep track of the patient while they were on treatment to ensure that any concerns or issues that they might have were being dealt with. If the patient wanted to talk with his/her PON in between treatment or clinic appointments they were told to

phone the nurse and leave a message, and the nurse would get back to them. How the team roles were enacted will now be discussed.

From Vision to Practice

Implementation considerations

The recommendations from the re-design project were accepted in principle by the steering committee, which consisted of the Chief Executive Officer and senior agency leaders in June of 1996. The covering letter circulated with the report indicates, “much more work is required before most of the re-design proposals become reality” (Correspondence, June 21, 1996). As part of the final patient care change report, the planning team identified anticipated barriers to successful implementation. These included; education related to collaborative practice, evolution to true collaborative and interdisciplinary care, and in particular “a change in the environment with its current definition of the nurse and the doctor/nurse relationship” (Patient Care Change Report, 1996, p. 8.1-21). The report does not elaborate or describe the relationship of the nurse/physician in 1996, but one can surmise that it was not as visualized by the planning team, or they would not have called for a “true evolution to collaborative and interdisciplinary practice” (p. 8.1-21).

The implementation plan contained in the report is very short and appears to only outline priority activities that would need to be attended to for successful implementation. One of these activities identified is staff education and training for the new roles, and also for the use of technology and care paths [or care maps]. I will now turn to an examination of the educational activities that were undertaken by the organization in the name of preparing nurses for the role of the PON.

From Nurse to Primary Oncology Nurse

Educational strategy

A review of organizational documents reveals a number of educational activities undertaken by nurses in the cancer clinics to prepare for their new role as PON. A competency based educational (CBE) program was developed for PON in ambulatory care. At this time the acronym was changed to Oncology Primary Nurse or OPN, which is the nomenclature that is used by nurses in my study. The underlying assumption of the need for an educational program is underscored by a quote taken from Itano, Piercece, Masten and Whitely (1992) “well-educated oncology nurses with the knowledge, skills, and attitudes needed to provide effective nursing care are a necessity in these times of increasingly complex cancer treatments” (p. 33). The CBE program was intended to identify the knowledge and skills necessary for a nurse to fulfil the OPN role.

CBE is described as an educational approach that emphasizes the learner’s ability to demonstrate proficiencies that are of central importance to a given task or role. The emphasis is on what a learner can ‘do’ versus what they ‘know’ (Del Bueno & Altano, 1984; Del Bueno, Barker & Christmeyer, 1980; O’Grady & O’Brien, 1992; Staab, Granneman & Page-Reahr, 1996). CBE is espoused as an educational method suitable to teach both novices and experienced nurses to develop new skills and/or change roles (Alspach, 1995). One of the source documents utilized to develop the CBE program was an educational program developed by Lin et al. in 1993.

Lin et al. (1993) describe a CBE program developed for ambulatory nurses. Their CBE program was designed to improve ambulatory oncology nursing practice and illustrate the knowledges dominant in oncology nursing practice characterized by

“competencies related to disease processes, treatment protocols, and supportive care” (p. 56). Although the need for comprehensive, current knowledge is espoused as the reason for the CBE program, the rationale given by Lin and her colleagues is more related to staff satisfaction, staff self-perceptions, standards of practice, and the need for a primary nursing model to “give staff the opportunity to practice at their highest potential” (p. 54). The educational approach taken is described as “flexible enough to accommodate nurses’ experiences, competencies, professional, and learning styles, method of practice, and yet also foster a positive group process and self-esteem” (p. 55). This approach appears to be focused on the needs of nursing staff rather than on meeting the needs of patients, and is built upon the assumption that if consensus can be achieved through educational strategies, then quality of patient experiences will follow. The educational program was considered successful and this was indicated by,

The learning needs assessment scores improved, participation and collaboration in patient care increased [and] overall feeling of empowerment was voiced by nursing staff [and] increased nurse-physician collaboration, growing assertiveness, implementation of the primary nursing model, an increase in nurse-to-nurse consultations, and an overall interest in identifying further topics to explore (Lin et al. 1993, p. 62).

These outcomes have been taken by Lin et al. to be measures of patient benefit, as the initial goal of the program was to meet patient needs. At best, these outcomes can be construed as indirect measures of patient benefit and then only if one subscribes to the belief that satisfied nurses result in satisfied patients. This type of educational approach is problematic in that it foregrounds the professional needs of the nurse and the needs of patients are relegated to the background.

Keeping in mind that the patients are meant to benefit from nursing actions it is unclear how nurses reconcile professional benefit rather than patient benefit. The

assumption appears to be that nurse satisfaction can be taken as a proxy for patient satisfaction. Additionally as indicated by Del Bueno and Altano, 1984, “competency-based education is not a panacea for all the ills of the organization, nor is it a magic feather whose touch somehow transforms new employees into competent performers. Strategies and tactics can affect learning, if those involved want them to work and are willing to commit energy, time and money” (p. 53). In other words, even if nurses achieve the competencies identified in a CBE program, there are other influences that will impact their ability to be transformed into competent performers. As I suggested previously, a competent performer may or may not result in benefit to the patient but may merely do no harm.

In attempting to put the current practises of the participant nurses in the context of the recommendations from the review, I found it difficult to ascertain what the educational process had been to assist the nurses to take up the role of OPN. Organizational documents reveal that educational sessions regarding the role of the OPN were held with nurses in 1997 and 1998. Notes from one of these sessions in September of 1997 describes that moving to the OPN role is a “journey of transformation.” Part of that journey was the development of a shared vision of the OPN role that would “guide practice, enhance care, grow and evolve and know who we are and negotiate [nurses] position on the team” (Cancer Agency, Workshop Notes, 1997). This descriptor of the vision, similar to CBE, implies that patient benefit is somehow related to the nurse’s professional goals to find a place on the team.

In terms of fulfilling the other key requirements for changes such as collaborative practice and interdisciplinary teamwork, I was unable to find documentation that showed

how this was dealt with by the organization. In discussions with the nurse participants it would seem that the education they were provided focused on their role and that other sessions were held at the other clinics to discuss how the team would actually work together. Following, I will explore how the participant nurses talk about the organizational changes as they relate to the OPN role, interdisciplinary practice and observations of practice in the ambulatory clinics.

In the beginning

The role of the OPN was intended to provide a consistent person for the patient to interact with as they moved through the various aspects of care and treatment at the cancer clinics. The role description resonates with the expression that many of the nurses and patients have taken up that refers to the cancer experience as a “journey” and thus the OPN is positioned as a guide in this journey. At the time of this study in Meadowview, the role of the OPN had apparently been in effect for approximately three years and was currently undergoing changes. N4 at Meadowview describes her perspective on the role of the OPN in the ambulatory clinic after it was implemented in 1997.

N4: We were geared with the physician, so we knew where the physician was, the nurse was, the patient was.

LS: And how long, how long did it work like that?

N4: It worked that way for the first three years beautifully.

LS: So [name] can you just tell me then a bit more about when you say it worked beautifully, tell me what aspects worked beautifully, like, what was it about that that worked well?

N4: Well because you were the true oncology primary nurse. The patients came in and you were their first introduction. They met a unit clerk first thing down the hall there and then you spent at least a half hour to forty-five minutes with the patient finding out where they were so far in their

journey because they've already seen a number of specialists. Often they have been diagnosed with new cancer [my emphasis].

LS: Right, right.

N4: You're the actual person that's sat down and often sort of told them exactly what's *probably happened to them* and is *going to happen with them* [my emphasis].

LS: Uh huh.

N4: And then you're able to assure them, but by the end of the visit that they're going to have they're going to sort of know where they're going from here because they know that, um essentially the buck stops here for these are the oncologists and the cancer specialists. But they also know that there's a nurse to support them the whole way through that they're going to be *taught* everything very systematically and thought out process here. So that worked well and we're always with um, the nurses were teamed with the physicians so they were site [tumour site] specific. Cause all of the physicians have certain sites they are responsible for. And it just makes for accuracy for excellence, and it makes for um, them knowing exactly sort of where the patient should be in certain protocols. I mean they all *know everything* [my emphasis].

N4's reference to telling patients "what's going to happen to them" and that the patients would be "taught" everything begins to round out the image of the nurse as a guide for the patient's "journey." N4 indicates that nurses have knowledge to be conveyed to the patient. N4 also indicates that the physician "knows everything" and therefore shares the role of transmitting knowledge to the patient. There is no mention of whether the patient also has knowledge that needs to be conveyed to the nurse and physician.

N4's description of how the OPN interacts with new patients somewhat aligns with the description of the patient care model in the patient care change project report. The role of the clerk has some of the features of the envisioned role of the information coordinator position. N4 indicates that a new patient would see the nurse first and receive support and systematic teaching. The key feature of this particular depiction would be the time that the nurse seemed to have had with each patient. From the

observational materials and as discussed previously, time with patients is through the physician's schedule. Nurses appear to have a minimum amount of time to spend with patients unless they exercise discretion to act outside of the schedule as discussed in the previous chapter.

In her description of the benefits of the OPN role, N4 indicates that the patient receives support during the duration of their cancer journey. They also receive information and teaching to assist them. Prominent in her depiction of how things worked beautifully is the positive comments regarding the alignment with a physician. I suggest that alignment with the physician serves to legitimize the nurse as a team member. Team membership requires that the physicians accept the nurses as members. Munro (1999) suggests the identity of others can be affirmed by the membership or members can defer affirmation. In this case, the affirmation of nurses as team members is essential as the nurses' access to the patient is through the physician schedule.

The role of the nurse was scrutinized during the organisational review and the movement to the OPN role was deemed by the review team to be necessary. Nursing work is often referred to as invisible as it occurs behind closed doors (Street, 1992). Pairing nurses with physicians can be construed as one way of seeing that nurses account for their time with patients by making the invisible more visible. Surveillance by the physician in these partnerships is assured by the manner in which the nurses give a report to the physicians on their interactions with patients. The following interaction with a patient and subsequent report to the physician typifies how accounting for time spent with patients is a regular part of the routine of care conducted by nurses in the ambulatory clinics.

- 0910: N5:** Calls to the waiting room. Mr. Peters, can you come this way. A gentleman looking about 65 moves from the waiting room and follows N5 into exam room 2 and sits in the chair. According to the information on the schedule and his chart, he is at the clinic for a 3-month follow-up post-radiation treatment for throat cancer.
- N5:** How are you today? She is standing beside the exam table.
- Pt:** Fine (he speaks with a slight French accent and his voice is raspy. he appears very jovial).
- N5:** Any problems with swallowing or breathing?
- Pt:** No not really, but if you smoke what do you expect and I am not stopping!
- N5:** I am not going to tell you to stop smoking. Any problems with your energy level?
- Pt:** Well I get a bit winded if I walk too far, I go around the block about 4 times and I am tired.
- N5:** Well that is to be expected. Do you still work outside of the home?
- Pt:** Not anymore, I used to be a businessman in Montreal.
- N5:** So what do you do now to keep busy?
- Pt:** Oh, I have grand-kids and I like to garden.
- N5:** Well let's weigh you and see how things are.
- Pt:** Moves from the chair to the scales.
- N5:** You are about the same as you were before.
- Pt:** Well that's good.
- N5:** Well, the doctor will be in to see you in a minute.
- 0914: Pt:** Okay. We leave the room, elapsed time 4 minutes. We go into the workroom and N5 reads the patient's chart.
- 0916:** The physician comes into the work area and puts her hand out for the chart. N5 gives her the chart. As she reads N5 tells her about the patient. He has no symptoms, is pretty feisty, has no intention of quitting smoking and his weight has not changed since the last time. The

physician nods her head and continues to read the chart. N5 has only documented the patient's weight.

In this instance, the role of N5 appears to be one of screening for the physician. The answers that the patient supplies to N5's questions are accepted by N5 without any further probing or query for elaboration. When the patient indicates that he becomes winded upon exertion, walking around the block, N5 normalizes this symptom by indicating that is to be expected. By doing so, she tacitly implies to the patient that he needs to learn to live with the fatigue, as she offers no ideas regarding strategies that might mitigate his tiredness. An opportunity to both support and educate the patient (which N4 described as fundamental to the role) is lost in this encounter in an effort to ready the patient for the physician.

Fatigue is a well-recognized symptom in cancer patients. The literature on symptom management indicates that it is important for patients to try and maintain and increase their exercise levels as inactivity only serves to increase fatigue (Nevidjon & Sowers, 2000). N5 might have expanded upon her comments regarding the expected nature of low energy but also encouraged the patient to continue with his exercise. She could have given him some ideas about how he might decrease his fatigue by walking two blocks twice daily rather than four blocks once a day. Also she could have indicated to the patient that the feeling of fatigue would eventually dissipate as the side effects of treatment wore off which can take up to a year. The patient's weight was another opportunity for the nurse to support the efforts of the patient to maintain weight and also to do some brief teaching regarding the relationship between good nutrition and fatigue and energy.

The verbal report to the physician appears to serve the purpose of checking in with the doctor to let him know what the nurse has found out about the patient. Much of the information relayed to the physician is not documented in the patient's chart. When asked about the lack of documentation, the nurses indicate that they don't have time to chart. The difficulty that arises is that without documentation the continuity for the patient is lost from visit to visit. In this example, no record was made of the patient's self-report of tiredness and feeling winded and therefore on the next visit it will be difficult for the nurse to follow up on symptoms to check and see if the patient has improved. Documentation is one way where the nurse could indeed play a role in facilitating consistency in responses to patient's concerns by transferring knowledge about the patient gleaned from the patient into the patient record. The patient would ultimately benefit from this knowledge exchange.

Nothing really changed?

The contrast in organizational influence of the re-design process is apparent between Meadowview and Brookline. At Meadowview, the nurses talk about their current practice in relation to the goals of the organizational re-design recommendations related to the patient care team. The nursing staff at Brookline only talks about the re-design if directly asked. They do not refer to themselves as OPN and do not make reference to nurse/physician dyads or partnerships. When directly asked about the re-design process and the introduction of the role of the OPN, the following comments are somewhat typical of the perspective of the participant nurses at Brookline.

LS: Switching gears a bit. In talking about the work in the other centres, not quite as much of it comes up, that is the discussion around oncology primary nursing. And I am interested, from your perspective, what that

means I guess to you, and here in the clinic in terms of how the role works.

N6: Well I think my idea was that within the context of tumour site teams there would be a, you know, a more concrete style of primary nursing, but it's very difficult to do in the centre because of, you know, just the number of clinics you have and you know, the switches that have to be made a lot of times [sick calls, vacation] and because some of those sites are *very, very big* [my emphasis].

LS: Yeah.

N6: There were three nurses as part of the breast site team, there wasn't just one nurse supposed to be a breast site team nurse.

LS: I see.

N6: So I mean if we were off, if I was off, then there was another breast site team nurse there that you know.

LS: Oh, okay, I see.

N6: But it didn't matter which nurse, as long as they were within the site team.

LS: Right.

N6: And you know, I think, we were just becoming a sort of cohesive group when there was another change and...

LS: So what prompted the change?

N6: I think the re-design was part of it, and as you may be aware, I mean the focus from the old nursing role to OPN you know sort of changed within two years, so there was a bit of disorganization and confusion even within what was going to be the nursing role, I mean, you know the assigning a nurse to a physician didn't work because we don't have enough [nurses].

LS: So did that ever happen here?

N6: **Nods her head no.** We didn't have the numbers of staff to support it.

LS: So the site team concept didn't really carry on, but the new concept of OPN didn't actually start here either. So what happened here, in terms of primary nursing?

N6: Well I think it got fragmented.

Further N3 at Brookline commented that during the organizational re-design,

We kind of got pushed and shoved out of the way with our whole idea about the team concept and we had to labour through this [organizational change] only to come out the other end with the fact that there is not enough staff to go with the primary nurse model as far as nursing was concerned. It's a really nice idea but not a practical idea.

The perspectives of N6 and N3 that the role was never taken up by either the nurses or other clinic staff at Brookline is not readily apparent in the observational materials. The physicians are scheduled according to sites [tumour] and the nurses are also aligned with particular tumour sites. The nurses do not describe themselves as being a particular physician's nurse, but do describe themselves as being, for example, a breast nurse or a GI [gastrointestinal] nurse and so on. Although at Brookline the participant nurses suggest that the OPN role was not implemented as it was in Meadowview with the pairing of a nurse and a physician, their alignment with the tumour site teams is very similar to that of the pairings. They tend to work with the same group of physicians over time and get to know each other's habits and work patterns. Further, the observational materials suggest a remarkably similar pattern of practice in the ambulatory clinics between both Meadowview and Brookline. So regardless of how it is that the nurses talk about their work, observations suggest that there are more similarities than differences in how they look after patients, and work with physicians in the two study clinics.

Working Together

Pippy (2001) suggests that one of the benefits of being aligned with a physician in the ambulatory setting is the power to stay connected with patients and families. In other words, being part of a physician's practice enables the nurse to interact with patients and families in a way that is seen as legitimate by administrators, physicians, other nurses,

and patients. Pippy discusses how this potential benefit is truncated depending on the individual physician, ability of the nurse to forge a relationship, and so on. Street (1992) suggests that nurses' practises are modified depending on physician practises and that nurses learn which physicians value their contributions and those who do not. At Brookline, N3 describes how a new patient visit proceeds and provides an example of how the practice of report is modified depending on the physician.

N3: We do an assessment, talk with the patients and then after we've done that, as it stands now we give a brief report to the physician following our visit with the patient. And that depends on the physician, and it's meant to be not a medical report. It's meant to be more of a *nursing report* to the physician [my emphasis].

LS: I would like to pick up on what you said and that was the notion that depending on the physician you give report. So tell me a bit about that.

N3: Well, for example in gyne clinic, we have a conference before we start our new patient clinic. So all of the patients' charts that are coming in that day have been reviewed as to their pathology which is reviewed at that time, as well as the doctor, whoever is presenting will do, will read a brief history that has come from the physician who referred the patient.

LS: Right.

N3: So the doctors have a nodding acquaintance with what's going on with that patient. Also for Dr [name] has often done a lot of the surgery on these particular patients coming through.

LS: I see, I see.

N3: The other doctors in the clinic often will, um you know appreciate just a little snap shot or what we feel might be important for them to know in terms of our assessment.

The "nursing report" that N3 indicates is given to the physician is a verbal summary of what the nurse has gleaned from the time spent with the patient. In the case of new patients, the information has also been written on the health assessment form by the patient. For follow-up patients it is the information that the nurse manages to gather

in the 3-5 minutes that he/she spends with each patient. It is apparent from N3's narrative that not all of the physicians are interested in the nursing report that is passed on in the "snap shot" of the patient. As indicated in the gyne conference, the physicians are focused on the pathology report and the history from other physicians. This rational, scientific approach to patient care serves to perpetuate the role of the physician as expert and positioned at the top of the hierarchy. The information that nurses provide related to patients may or may not be taken up. Thus the power of the physician is demonstrated by the role they play as gatekeeper of knowledge about the patient. They decide what information to let in and what to keep out.

Membership

Garfinkel (1967) suggests that members account for their actions in order to let each other know as part of mutual surveillance but they also need to know when they are being asked to sanction an account (cf. Munro, 1999, p. 434). Garfinkel indicates that members sanction accounts and in the absence of affirmation a breach in membership occurs. In this case, being a member of a team is highly valued by the nurses and is espoused as desirable in the organizational values. Therefore, the sanctioning of accounts [nurses report] by the physicians is not only a mechanism of control of knowledge about the patient, but also a barrier to membership by the nursing staff. Munro (1999) indicates that the lack of affirmation can result in the either exclusion of membership or the "opening up" of the question of membership (p. 435). The question of membership is prevalent amongst the nurses, whose membership on the nurse/physician team occurs at the pleasure of the physician. Active membership is demonstrated differently amongst the participant nurses for a variety of reasons.

Pippy (2001) suggests that if the partnership between nurses and physicians is unbalanced that nurses may experience frustration and moral distress. My observational materials suggest that the nurses are active participants in building partnerships with physicians. The partnerships are in part related to individual personalities but more importantly, the organizational forces that affect those relationships are dominant. This is apparent in the contrast between how the nurses were influenced in Meadowview to take up the role of the primary nurse whereas in Brookline the nurses were influenced to be 'site' team nurses. Neither group of participant nurses overtly recognises the similarities between their respective practices, as the discourse that they used to describe their practice is the language that is prevalent in the respective clinics.

The nurses in Meadowview derived some benefit from their role in the nurse-physician partnerships. This is underscored by N5 commenting on the changes in the ambulatory clinics that occurred just prior to this study where the nurse/physician dyads were no longer in place at Meadowview.

N5: Well the changes, well I always think with change there's good and there's bad. The good part about it has been that I am, I'm very clear in what, in my role here. Whereas before [the OPN role] you were, you were working with the doctor and you were putting patients in [exam rooms] and you weren't looking at, you weren't looking at where *you were needed the most* [my emphasis]. Ok? Because you were, you had the time.

LS: Sure, I understand.

N5: You actually put patients in [exam rooms] that *were doing well* [my emphasis]. The good part about that was, is that it was a little break in your day.

LS: Yeah.

N5: The down side now is that you, because of the way the schedules is, you're not, you have two or three doctors, you can't be in three different

places at once. And sometimes you *don't need to be*, but a lot of times you do. Yeah. [my emphasis].

LS: Okay.

N5's description of how they enacted the OPN role prior to the most recent change indicates that they saw all the patients in the clinic, even if the patients were "doing well". N5 does not elaborate on how it was that nurses decided who is "doing well" and who isn't. She skips over this as if it is obvious to everyone. Similarly, describing how work was currently organised, she indicates, "sometimes you don't need to" [see all of the patients]. Again, N5 does not elaborate on the knowledge that the nurses draw upon to make these determinations.

There are several influences at play in this excerpt. Firstly, N5 suggests that all patients do not need to be seen by the nurse. This assertion contradicts the original organisational aim of having the OPN be the consistent link in the patient's journey. N5 has picked up on the notion that nurses need to focus on where they are "needed the most." My understanding from discussions with the two Nurse Leaders at Meadowview, is, as the number of patients increased, there were not enough nurses to see every patient. Although N5 alludes to having had time in the past, she has constructed this increase in workload and change in practice as being more focused on patient need rather than workload. There is no mention of how this change impacts consistency. Continuing on with her discussion about how the OPN role worked at Meadowview, N5 goes on.

N5: And when you are working with one physician, a few could say, well it's not really primary nursing, it's primary doctor, but I don't agree with that. Do you know what I mean?

LS: Tell me what you mean.

N5: I think the whole concept of it is that you, there's a real team approach so that you can spell each other off. The fellow that I usually work with, came to me yesterday and he says, I'm very overwhelmed by calls and I have three calls in to patients that are not doing well, and I'm worried about, do you think you *could call them for me?* Do you have any time to do that? And I said sure. So it's kind of a nice team feeling that you're part of and that's really satisfying [my emphasis].

The pairing of a nurse with a physician at Meadowview after the re-design was seen as positive by the nurses. N5 describes the feeling of satisfaction that she has in working with a particular physician due to the fact that the physician can rely on her to help out when he needs it. N5 defends the partnership in the name of teamwork and the example she gives points to the overlap that occurred when they were paired. Her reference to primary doctor indicates an awareness of the perspective on the part of some of the nurse leaders, other nurses, and administrators that the partnership between nurses and physicians developed into more about helping the doctor run his clinics rather than in providing comprehensive, consistent care to a population of patients. This perspective is apparent in the words of NL4 when asked about the most recent changes resulting in the uncoupling of nurse/physicians in the ambulatory schedule.

LS: Now what response have you had from the physicians?

NL4: Um, related to the ACU [ambulatory care unit] changes?

LS: Yeah, Yeah.

NL4: Not very good either. Um, most of them have complained to [name], um. Most of them say "I want my nurse." Nobody has really been very clear and articulate about which patients needs to see the nurse. But they say, "well you've taken my nurse away." Um, you know a couple of them will say, yes I know, we understand that, you know, we can't continue to do things the way we always did, but it was really much better the way it was before. And they continue to foster the animosity I think as before. A couple of them have worked really hard with the nurses that they are working with in their clinic team. They will do things like, you know what was really talked about initially [in the Patient Care Change Report] like go to the clinics early in the morning, not early morning, but you

know, if it starts at 9, and meet as a team and talk about the priorities as a team and who needs to see the nurse and who needs to see the physician.

LS: And some actually do that?

NL4: And some of them still do that. Some have never taken that on, and some started it and then didn't like it and wanted to be independent. You know there are some physicians who have really bought into working as a team and there are some who still see themselves as independent practitioners that really aren't accountable to the organization or the team. So those are the groups that have a hard time. And the ones that seem to be doing the best are the ones who have *real patient issues* that you know, *they're good at*, they're already good cause their site [tumour] teams are working well and they've really come together. You know like I'm thinking about the gyne group, the head and neck group. Those who have high needs patients.

NL4 indicates that some of the physicians had complained about the most recent changes where the nurse/physician dyads have not been maintained. Although there is an acknowledgement that changes were necessary [I presume due to increasing patient volumes], the physicians did not want the dyads broken up as the physicians were also reaping some benefit in that relationship. NL4 speculates that when things are working well, it is because there are "real patient issues" for the nurses to deal with and that makes them "real good." She goes on to suggest that the high needs patients such as "head and neck," and "gyne patients" require nursing and therefore the partnership between physicians and nurses works well.

Although NL4 suggests that different patients have different needs, she is talking in terms of populations of patients, not individuals. NL4 speculates that given that patients have "real issues" that the nurses should be focussing their attention on those patients. I was not able to observe that the relationship of nurses looking after certain populations was any different than others looking after other populations. The needs of patients are further compartmentalized into symptoms, side effects, and expected

behaviours. This is another example of categorizing patients by some type of normalizing prediction of how they [patients] may or may not react to their diagnosis and treatment. Latimer (1993) suggests that this type of division provides a formula for nurses to “routinize their responses” (p. 163). Latimer goes on to suggest that these routinized responses provide a frame of reference for the nurses’ practices. In this case the frame of ‘expected’ responses to particular cancer treatments shapes the way in which nurses interact with patients, the questions they ask and the responses they give. The knowledge that nurses identify that they require to make these predictions is tied to their concept of oncology specialty practice and mirrors the prevalent medical view of patients.

Specialty Practice

Oncology expert

At Meadowview, the role of the primary nurse and the knowledge required to fulfill the role requirements [before the changes that occurred just prior to this study] are described by N4.

N4: We had a special focus. So that helps with nursing needs, patient needs as well.

LS: So when you, when it was working like that what were you doing?

N4: I was um, a special, I became a specialist. Like, remember I came here as an in-patient transplant specialist, so it was very different. So I came here and I had to really learn new things. And I *learned prostate cancer* [my emphasis].

LS: Uh huh.

N4: Testicular cancer and lung cancer very, very well.

LS: Okay.

N4: And um, what I learned was um, it took me I'd say you know to go from novice total novice, cause I was a total novice to I would say probably expert now, it took me over I'd say 12-14 months. And it was a lot of reading on my own.

N4 indicates that she “learned prostate cancer” and identifies herself as an expert and specialist in testicular cancer and prostate cancer. The special focus relates to the tumour site that the patients are categorized into. In contrast to previous comments, about support and education, N4 focuses on the learning about the particular cancer that she needed to do to become an expert. Previous to this experience, N4 describes herself as a specialist transplant nurse [also with cancer patients].

As previously discussed in Chapter Three, the concept of expert and specialist dominates the oncology nursing literature. The oncology specialty has been endorsed by the Canadian Nurses Association and certification (CONc) is a sought after credential by cancer care organizations in their recruitment advertisements. The role description of the OPN in the Patient Care Change Report (1996) in the section Education and Skills indicates that Oncology Nurse Certification is a requirement for the role. Specialty practice is modelled on physician specialities and in the case of oncology, further sub-specialization into tumour groups also parallels the approach that oncologists have taken to identify their specialty practice within the group of cancer patients.

An uncritical view of oncology specialty practice would suggest that membership in the oncology *club* has necessitated that nurses take up the specialty focus. However, similar to the discussion in the previous chapter, related to the discretion of members in regards to the ambulatory schedule, nurses are active participants in constructing the specialty model of patient care. However, there are powerful influences at play that endorse specialty practice. The nursing profession in Canada sanctions specialty practice

and has set up examinations and certifications that further affirms membership in one of the specialty areas of practice. Membership in specialty practice separates nurses from other nurses, categorizes them and aligns nurses with physicians who share a specialty focus. For example, there are many categories of specialty practice nurses including neurology, critical care, emergency and so on. All of these specialties are directly aligned with a medical specialty. I suggest that nurses benefit in their relationships with physicians by sharing a specialty practice. At the cancer clinics individual nurses benefit from membership in teams with physicians and also as a member of the oncology nursing specialty group. However, it is questionable whether the nursing profession as a whole has benefited by categorizing its members by specialty modelled on physician specialties.

Expert practice

In this study, nurses further label themselves and each other which creates yet another area of differentiation between the nurses. They all consider themselves expert oncology nurses and for example, N2 is referred to as the pain and symptom management/palliative care nurse, and N7 is referred to as the chemo nurse. So within the specialty of oncology and the sub-specialty of tumour groups, the nurses have created yet more sub-groupings such as those in the examples above. Therefore the nurses actively participate in a self-categorization that provides the benefit of membership, and further legitimizes a role for nurses in oncology ambulatory care. Their view of themselves as experts also situates them in a position of control over the patients

A Patient by Any Other Name

The CANO standards indicate that oncology nurses “have a concept of the problems cancer patients may experience” (CANO, 1995, p. 8). They demonstrate this

standard by their ability to “state the common sources of problems for patients affected by cancer” (p. 8). The standards go on to describe that oncology nurses use the nursing process to collect and analyze data, plan and implement interventions, and evaluate the outcomes of their interventions. As discussed previously, this problem approach to care positions the patient as a being that can be sub-divided into a series of problems that the nurse is poised to solve. The difficulty with this approach is that it contradicts one of the goals of the organizational restructuring, which stated, “the specific needs of *each* [my emphasis] patient are recognised and addressed with compassion and respect” (p. 2-3).

When problems are identified “a priori” related to the common features of cancer patients, the uniqueness of each individual gives way to the normalizing of the collective. The normalizing practices serves to control the responses of patients/families and situates the nurses as the expert poised to deal with predictable concerns. Patients are categorized by both tumour and typical symptoms of both the disease and treatments.

Nurses suggest that they normalize patients’ symptoms in an effort to reassure the patient that what they are experiencing is to be expected and so they will not be worried about what they are experiencing (Carroll-Johnson, Gorman & Bush, 1998). However, I suggest that the normalizing of symptoms serves to silence the concerns of patients that are experiencing symptoms or have feelings that lie outside of those that the nurse has predicted. From the observational materials, when a patient raises an issue, rather than having their issue explored, they may not be fully attended to, as the nurse may have already anticipated this symptom, and is interested in asking about other symptoms. NL1 describes a new patient visit as follows,

On the new patient visit, it is a crisis. The nurse is there to help them through the crisis situation. To make sure they have what they need. To understand what

they need. First assess what that person needs, why they think they're here, what they need, what their family is like, what their support system is. You're trying to find out a bit about that person, then you bring in the medical, the treatment plan, which [you] could *have guessed* because they're just you know, their little factory things, and yes if you have cancer you're probably going to get this [my emphasis].

NL1 suggests that the patients are in a crisis and that the nurse helps them get through the crisis by finding out their needs. She goes on to indicate that the medical treatment is predictable and further suggests that the medical practices are somewhat similar to a factory. By suggesting that all cancer patients are in crisis, NL1 demonstrates the same type of action that she is critical of the physicians, that of presupposing what patients will need and what nurses will provide for them. Assumed to be "in crisis," the patient is further assumed to need support from the nurse. The patient is constructed as passive, in need of help from the experts. This negates the knowledge that the patient brings to this particular experience and takes for granted that nurses have knowledge to assist patients. Patients pick up the expectations of the experts and self-discipline their concerns to comply with what is expected of them. This will be discussed further in the next section.

Acting outside of the *norm*

The compartmentalizing of cancer patients into tumour groups with common problems and issues disciplines patients into acting in particular ways. Patients come to expect to be asked about their symptoms and many keep track of them in notebooks so that they don't forget any of the details that they might be asked about. Even when they collect information about themselves for the nurses and physicians, the information continues to be placed in the foreground only if it conforms to the questions being asked. Thus the physicians, nurses and patients all come to understand what to expect of one another during the clinic visits. When a patient acts outside of the expectations, there is

an attempt to explain the deviation from the norm. The following interaction between N5 and a follow up patient illustrates this point.

1150: N5 Goes to the waiting room and calls the name of the next patient. A middle-aged man who appears well follows her into the exam room.

N5: How are you? Hop up on the scales.

Pt: Are you busy today?

N5: We kind of got behind.

Pt: At least I am in now...**gets up on the scale.**

N5: Any new lumps or bumps?

Pt: No, I feel great, lots of energy, eating good.

N5: Any night sweats?

Pt: Yes, off and on, but not every night.

N5: Do they wake you up?

Pt: Yes, but only because I wake up freezing. Actually, I have never felt so good, I am eating right, exercising.

N5: That's great, anything else?

Pt: No.

1153: **We leave the room and go into the work area. N5 looks at the chart and then says to me. He is in denial because his prognosis is terrible. The physician comes into the work area and the nurse repeats her comments about the patient.**

Dr: Maybe not, he has responded very well to the last round of chemo and hormone therapy and likely does feel really good. Now that will change, but it might last for quite awhile. It's hard to tell.

N5: Oh, well, that is good isn't it?

The patient is described as "in denial" as his demeanour and self report of feeling great does not fit with the preconceived expectations that N5 has of a patient with that

particular cancer diagnosis and treatment regime. Disciplined to think about patients in a particular manner, N5 is unable to re-frame her own predictions of the norm and when faced with a patient who does not appear as anticipated, she turns the patient into a problem. By problematizing the patient's actions, the nurse produces the label of denial and attempts to substantiate her label with the physician.

The physician's explanation relies on the physiological aspects of the treatment that the patient is on. When the physician offers this explanation for the patient's behaviour, N5 is still unable to completely align her perspective with that of the patient and physician. Asking if "that is good" illustrates that N5 would prefer that the patient was acting more in keeping with his diagnosis and apparent poor prognosis. When patients act outside of the expected norm the nurses produce stories or accounts, that serve to perpetuate their original assumptions, and provide explanations about the patients that serves to control the sort of symptoms that will be dealt with. In this instance neither the nurse nor physician contemplate that there may be other than physiological influences that may account for the gentleman reporting, "I have never felt so good". I suggest there are other influences that may account for the man's feeling of well-being, that are effectively silenced as they do not fit into the lens through which the nurses/physicians view oncology patients.

Summary

The nurses at Meadowview and Brookline talk about their practice in somewhat different ways, for example OPN rather than site teams. They talk about the patients using the same language as their medical colleagues. Nurses refer to patients by tumour site, for instance, breast, GI, lung, and so on. This frames not only how they think about

cancer patients but also how they proceed with their practice. This similar framework for thinking and caring for patients produces practice that is remarkably similar across the two clinics. The observational materials reveal patterns of practice that align with the organizational goals of efficiency. The goal of treating patients as unique individuals is not readily apparent in these practices.

Nurses working in the ambulatory clinics model their practice and behaviour to align with that of their physician colleagues. This serves to legitimize their role with patients and also as a member of the team. Team membership appears as much dependant on the individual perspectives of the physicians as it does on the ability of the nurses to build relationships with these colleagues.

Taking up a problem solving approach to patients, the nurses structure their interactions with patients according to a set of preconceived notions regarding the so-called 'typical' concerns of cancer patients. Nurses talk about becoming experts in particular tumour groups and further sub-divide the specialty nature of their practice by labelling themselves, and each other by both particular tumours, and also treatment modalities. The categorization of their work necessitates the categorization of the patients to ensure that they align with the particular expertise of the nurse and physician. This serves to discipline patients to react in certain ways that are prescribed to particular cancer patients. Falling outside of predictable behaviours is dealt with by further labelling patients and accounting for the difference. The next chapter explores further knowledge that nurses espouse to draw upon to care for cancer patients. The power relations attached to knowledge is discussed in relation to the impact and influence this has on both the conduct of nurses and patients.

Chapter Eight: Making a Difference?

Introduction

The last two chapters have been concerned with typical practices of nurses, primarily in the care of follow-up with patients in the ambulatory clinics. These practices were held up against the aims of the organizational change initiative, and alignments and contradictions were addressed. Power/knowledge relationships were explored and arguments were advanced that offer a theoretically robust description of how nurses have come to practice in particular ways. The patterns of practice that have emerged from the data, explicated in Chapters Five and Six could lead one to believe that oncology nurses simply follow orders, and that the knowledge that they draw upon in their practice is that of medicine. This view is incongruent with how nurses and nurse leaders talk about practice, much of the oncology nursing literature, and the claims of their professional organization, CANO.

Practice has been observed to be remarkably similar in both of the clinics even if the talk is not. This chapter is concerned with exploring practices that reveal patterns that are somewhat different from those that have been previously discussed. I further explore practice in the ambulatory clinics turning now to the new patient appointment. In the case of new patients, practice between the two clinics appears different and an uncritical reading could lead one to believe that the influence of the organizational change appears to have resulted in practices changing. I suggest that there are other influences at play and lay those out in this chapter.

I advance an argument that the knowledges that the nurses draw upon in the patient's first appointment are more readily explained by the nurses than the knowledge that they use in caring for patients in the follow up appointments, and is apparent in their

practise patterns. Nurses talk about what they need to ‘know’ in order to look after patients on their first appointment. Observational materials reveal the type of knowledge they apply in a new patient appointment. They rely upon their ‘expert’ knowledge of cancer diseases. The question that seems worthy of exploration is how these clinic practices emerged in the context of the change initiative and the knowledge that nurses say they use in the new patient appointments. I suggest that explicating how emerging practices take hold in the shadow of the change initiative sheds light on influences other than those orchestrated in the name of the organization.

First Appointment - Context

Cancer diagnosis - patient’s perspective

In the Patient Care Change Team Report (1996), there are several references made to the patient’s perspective. It is not entirely clear how, or indeed if, input was gathered from patients, as the team membership does not include a patient name. The perspectives in the report appear more aligned to organizational processes than to what patients might articulate their needs to be. For example, the following is part of a section addressing the patient perspective in regards to referral/assessment/follow-up,

Duplication of the collection of information from patients will be minimized. Individualized care paths will provide patients with an overview of what to expect through their care. The PON will provide ongoing point of contact.... (p. 8.1-1)

Although these points are perhaps important to the flow and efficient running of the clinic as discussed in Chapter Six, I suggest that they do not provide insight as to what is important to patients when they have an appointment in one of the ambulatory clinics. There are, however, multiple sources of information regarding patients’ needs. According to patient reports, the diagnosis of cancer marks the beginning of a significant life change. A cancer patient states,

“You have cancer” is one of the most feared medical diagnoses. It’s right up there with loss of sight, degenerative nerve and muscular disorders, brain damage, “flesh eating disease” and AIDS. (Cotter, 1999, p. 61)

The self-help literature for patients attempts to identify many of the common questions that people have when they are first diagnosed. Patients report concerns about wait times in a period where they are very anxious and afraid. When asked on her first visit what she expected to occur, a patient stated,

I expect to wait! I had a mammogram four months ago that showed something, then I had to wait to see the surgeon, who booked me for a biopsy, and then I waited for the results, and then I had to have more surgery, and then I had to wait for the results, which showed that I had some hot spots, so then I had to wait to come here to see what further treatment I need (Observational Notes, 2001).

Thorne, Harris, Hislop, and Vestrup (1999) studied the experience of waiting for diagnosis after an abnormal mammogram and suggest that, although experiences varied, patients identified common problems with the diagnostic process. They also indicate that although women identified the “importance of access to appropriate and accurate information,” there was variation in terms of their “needs and preferences” (p. 49).

Thorne et al. state, “many of the women appeared particularly insightful about their own information needs” (p. 49). In other words, women identified the information that would best meet their individual needs and at what time. In her self-help book, Cotter observes that patients may feel overwhelmed by information that they are given by well meaning friends and also health care professionals. One suggestion that she gives is to have a friend or family member accompany them when they see the physician as they may have difficulty remembering what is said to them.

Depending on the type of cancer that a patient may have, they may or may not have a definitive diagnosis prior to their first appointment at the cancer clinic. Often they have been told that their biopsy was *cancerous* [my emphasis] but the ramifications of

this may not be clear until all of the diagnostic information has been collected and put together to provide a complete picture. This can take days, weeks, or months. In the case of breast cancer, a biopsy often confirms the diagnosis. However, in colorectal cancer, a diagnosis can take months before the general signs and symptoms of bowel difficulties finally result in a diagnosis (Behrend, 2000).

Some patients describe themselves as being exhausted by the build-up to the diagnosis particularly if they have been feeling unwell during this period. In a recent study by Fitch, Deane, Howell, and Gray (2002), women discussing the peri-diagnostic period before being diagnosed with ovarian cancer, “still carried [after a period of 12-13 months] a sense of anger about the communication process between themselves and the physicians involved during this period” (p. 158). Their anger was based on their perception that their concerns [symptoms] were brushed off by physicians and attributed to childbirth, menopause, or a stress response. Even when symptoms were being investigated, many of the women felt that they were not taken seriously which impacted their trust in the system and practitioners during a period of time filled with uncertainty. Fitch et al. suggest that, in these types of cases, patients are “physically and emotionally spent, leaving them vulnerable and in a weakened state” (p. 152).

Cotter (1999) suggests that cancer patients should not compare themselves to other patients as no two circumstances are the same, and, as each individual is unique comparisons can be misleading. Thorne et al. (1999), describe the differences in how women went through waiting for diagnosis. Some want enormous amounts of information, some want very little. Some need to talk to health care professionals others do not. Some were angry about the wait and tried to influence the time, and others

followed prescribed procedure. Some shared the preliminary information with loved ones and some kept the information to themselves. The women experienced a wide variety of physical and psychological symptoms while waiting including “insomnia, panic attacks, inability to concentrate at work, inability to plan [and] gastrointestinal upset, tearfulness, and preoccupation with fears” (p. 45). One patient describes her feelings about her first appointment to the cancer clinic this way,

Two weeks later, I walked into the cancer agency- not in my usual role as someone with a PhD, and appointment in the Faculty of Medicine, and nearly 30 years’ experience as a healthcare professional - but instead, as a ‘breast cancer patient.’ This time, things were different. This time, my confidence was gone. Dr. Susan Harris (1999) – Cancer Patient, Professor, and Dragon Boater.

From the preceding accounts, we see that patients come to their first appointment at the cancer clinic having had a wide variety of experiences with the health care system. These patient experiences--brief or lengthy, positive or negative--will be interpreted by patients in the context of the knowledge that they bring to the situation. Cotter tells patients that,

Knowledge is power, and you hold the balance of power here. The fact is that you know more than anyone about yourself-important things like; how our body feels...the nature of your beliefs...the power of your will...and what you want to happen. *Or at least, you should know.* (Cotter, 1999, p. 114)

The suggestion that patients hold the balance of power is incongruent with the expert view that oncology nurses hold, based on their knowledge about all things oncological. I now go on to discuss the context of the patient from the nurse’s perspective.

Professional perspective: Academic influence

As previously described, oncology nurses frame their practice by several conceptual frameworks. Oncology standards, specialty practice, individualized care, and a model of primary nursing are held by nurses as part of the knowledge that they have of patients. In addition to these conceptualizations are the text books that nurses use to gain

knowledge about oncology. Two popular texts, one by Clark and McGee (1992), and the other by Otto (1996) outline for nurses the information that they require in order to be competent in the care of patients with cancer.

Clark and McGee present a curriculum designed to meet the standards set out by the Oncology Nursing Society, the American counterpart to CANO. The intention of the curriculum is to prepare American nurses for the certification examination. The curriculum is borrowed heavily by CANO and the information contained in the text is also used to prepare Canadian nurses for certification.

The text is divided up into major headings of Cancer Nursing Practice, Issues and Trends, Pathophysiology, Treatment of Cancer, and so on. Within the section on Cancer Nursing Practice, there is one chapter on the Nursing Management of Responses to the Cancer Experience. This chapter is divided into sections devoted to grief, anxiety, depression, fear, powerlessness, pain, insomnia, and other symptoms that cancer patients may experience while undergoing various treatments.

Each section is divided into theory, data collection, associated nursing diagnoses, nursing planning and implementation, and evaluation of client and family outcomes. For example, the section on grief is covered in a little over two pages, and covers all of the areas above. Theoretically, grief is defined, risk factors are identified, standard medical therapies are outlined, suggestions for data collection are given, as are lists of potential nursing diagnosis, nursing interventions, and evaluation of patient, client outcomes. In relation to the diagnostic phase, patients at risk for grief related to treatment are treatment described as those with [a] "diagnosis with a poor prognosis, uncertain outcome, or likelihood of recurrence" (p. 67).

According to the Canadian Strategy for Cancer Control (2002), 50% of those diagnosed with cancer will die of the disease [a poor outcome]. I would argue that according to this explanation, 50% of patients or more would experience grief.

I suggest that if nurses presuppose that patients who have a poor prognosis, poor outcome or reoccurrence will experience grief, they may miss out on patients that are grieving for other reasons. This is but one example of how nurses are educated to think of patients in parts, the emotional part separate from the physical part, and in a standardized manner. As previously explicated, this type of predictive approach is not congruent with the organizational change aim of meeting specific patient needs and concerns. However, it certainly does begin to meet the concept of care maps and/or guidelines for particular patient groupings, for breast cancer, colon cancer, and so forth.

Psychosocial care

The text Psychosocial nursing care-along the cancer continuum (Carroll-Johnson, Gorman, & Bush, 1998) “is aimed at those most personal components of oncology care—the heart and the home” (p. xi). The authors suggest that although there are many good references in relation to treatments and technologies, this text is intended to address the psychosocial issues of patients. They further indicate that although psychosocial information can be found in general oncology texts, this is the “first resource available for nurses that specifically addresses psychosocial oncology care” (p. xi). Although the content is intended to focus on those aspects of care that are in the background of other oncology texts, this text follows the same assumption that you can separate the psychological and social from the physical.

In this text there are three pages devoted to the patient's diagnosis; these are divided as, receiving it, response to it, family reactions, and life span considerations. A wide variety of patient reactions are briefly mentioned and there is a brief section describing the role of nursing. The description suggests that the "important interpersonal role of oncology nursing is imparting information, communicating hope, and dealing with the many emotions that are part of the cancer experience" (p. 9). The authors stress the importance of assisting patients to control their responses to the illness, providing education about the disease and treatment. By "helping patients to confront intense and confusing emotions as nurses work in close proximity to patients is the essence of the *nurse/patient relationship*" [my emphasis] (p. 10). This statement could lead one to believe that the psychosocial aspects of oncology care are a priority for nurses. If so, it is somewhat surprising that this 1998 text is the first resource devoted to this particular focus.

The two perspectives, physical and psychosocial, present nurses with conflicting priorities concerning their part in the "nurse/patient relationship." In order to receive their oncology certification, the vast majority of the knowledge requirements are about the cancer disease process, treatments, side effects, and symptom management (Varricchio & Jassak, 1999). I now explore how nurses define their role in the light of these competing knowledge priorities.

The Role of Nursing

A nurse's perspective

Nurses in the study describe their role in the first patient appointment in various ways. N5 always lets,

The doctors do the *technical* things, um, the *teaching* more so and I sort of go into more of a *support mode* and how are they [patients] coping, and that kind of thinking, and I ask them and I find out what their questions are [my emphasis].

N5 also indicates that her role has changed due to the organizational changes. When she worked as an OPN she was primarily involved with patients with prostate cancer and she suggests that she was more involved, then, in giving them information. She goes on to explain further,

So I'm *expert* still in a few [cancers] but certainly, um, Johnny-come-lately in a couple, and I feel that the patients really suffer because of that. Cause I don't know a lot about breast cancer, I *don't know a lot* about um, you know colon cancers, or, you know, things that are very, very different. Cause when we were specialized they [patients] got really good defined knowledge from me but now I've changed to head and neck, I mean I'll be in a head and neck clinic or a skin clinic. I don't know, you know you can't know *it* all [my emphasis].

N5 suggests that she no longer has the knowledge of an "expert" in much of her practice, as she can't know "it" all. I assume that, by "it," she is referring to specific types of knowledge about the various cancers, in this case breast and colon cancer. She indicates that she doesn't "know a lot" and therefore leaves it to the physician to provide the "technical" things that she has equated with teaching. The knowledge required to be an "expert" oncology nurse according to N5 is somewhat consistent with the majority of information contained in oncology textbooks and in the competency requirements for certification (Clark & McGee, 1992; Otto, 1997; Varricchio & Jassak, 1999). However, this is not consistent with the notion of meeting the importance of the nurse/patient relationship. Fitch et al. (2002) describe the importance of a nurse's role in therapeutic exchange or the use of excellent communication skills in order to assist patients during the diagnostic phase of their illness.

In this part of the interview, N5 does not hold her "support mode" as part of her expert practice. For her, "expert practice" is defined by knowledge about cancer, rather

than knowledge about finding out about the person behind the cancer. I argue that the exclusion of the 'local knowledge' (cf. Foucault, 1979) by N5 in her depiction of expert knowledge is problematic. In privileging professionalized knowledge, N5 moves away from the detailed types of information about specific patients that nurses in practice could use to guide their practice. Ashbury, Findlay, Reynolds & McKerracher (1998) surveyed cancer patients' experiences and concluded that although their "treatment needs were being met, their individual needs were not" (p. 299). Individualizing care requires knowing something about that individual, not just about the type of cancer they have and the treatment options available. Views of the nurse leaders are somewhat different.

A Nurse leader's perspective

NL2: We get all hung up on primary versus associate [nurse]. I boil it down to what is an oncology nurse. What is oncology nursing? And it doesn't matter if you're a primary nursing model or a site model or a collaborative or team [model], it doesn't really matter. What are the basic principles that underpin oncology nursing, you know, the role of the nurse. And I think there are principles that need to be in any model of nursing or patient care and that has to do with *responsibility*. It has to do with *accountability*. It has to do with developing a therapeutic *relationship* with patients and for patients. So it's not so much about how you're aligned or assigned, but it's more about your commitment and your care direction [my emphasis].

LS: Can you tell me a bit more about this?

NL2: Well, according to your nursing standards. Just like if you're a physician, you have the same sort of thing whether or not you're a site specific or whether you're, you know organ specific or whatever. There are *basic elements* and *basic truths* to that, that care that you deliver. So from my perspective whenever we talk about site nurse or primary nurse, I just think that you are an oncology nurse and that as an oncology nurse there is an *expectation* that you provide a certain level of care. In this way, your practice is bound by these principles [my emphasis].

NL2 describes the role of the nurse using managerial terms such as "responsibility and accountability." NL2 believes that one of the conditions for the development of a

nurse/patient relationship appears to be the commitment of the nurse. In viewing nursing in managerial terms, this nurse leader conceptually detaches nurses from their local knowledge and attaches them to the organization by making their conduct reportable. Also of concern in this view is the positioning of the patient as a passive recipient of care rather than as a participant. In the overview of the patient's perspective, patients are encouraged by the self-help literature to be active participants in their care. "Ultimately it is YOU who will make the choices that will determine your specific course of treatment, if you choose treatment" (Cotter, 1999, p. 118). Therefore, a nurse/patient relationship can only take place if both parties are willing participants.

NL2's comments follow a prescriptive view of nursing in that, for her, nurses practice according to standards which she suggests are based on "basic truths." Further, NL2 indicates that the "expectations" of oncology nurses are set by these standards. I suggest that "expectations" set by professional structures such as CANO are only one way in which practice is governed. The organizational aims of the cancer clinics are interpreted by managers as "expectations" of a certain level of care. These aims, as well, to some extent govern the behaviour of nurses.

It is interesting to note that although this prescriptive view is also prevalent in nursing texts, there is some literature to support the relationship part of nursing (Cohen, Haberman & Steeves, 1994; Corner, 1997; Halldorsdottir & Hamrin 1997). As illustrated in Chapter Six, individual follow-ups concerning patient needs give way to running clinics efficiently. Therefore, the expectation of being on time, getting the patients through, and following the schedule have been established as "expectations" of practice governed by the managers and, in turn, by the nurses themselves.

Patient Needs - Nursing Knowledge

Predictable needs

When asked about the new patient appointment, N5 indicates,

The patients fill out the health assessment tool. One of the things I like about the form is that it lets me know what that patient's greatest needs are. Cause a lot of times the cancer is the least of their worries, and it is interesting. You know you think so somebody's coming in for a tumour on her breast and she must be terrified. But actually the biggest concern for her is she's got three little kids under the age of ten and what's going to happen to them and who will look after them while she has treatments. *It is interesting* [my emphasis].

In this discussion, N5 points out that patient needs may not be readily apparent just on the basis of their diagnosis. The example she provides illustrates what can be gleaned by asking patients about their needs. However, other than finding this "interesting," N5 does not place much emphasis on this particular aspect of care as she goes on to describe the first appointment.

N5: I explain what they are here for. And sometimes they are quite surprised that they might have to also see a medical oncologist [N5 works in radiation]. So I'll sort of say, you know, sometimes patients are treated with a number of things but the initial therapies that you will need is radiation. And because um, I'm pretty good now, I know what when I look in the chart usually, because I'm good now, I know what the patients are going to get.

LS: Yes.

N5: So, I can sort of *prime them for things*. And um, so that [in the] interview I usually try and I try and keep it, I try and keep *control* of that cause sometimes they can go off on a tangent. I just sort of use humour and just say, "oh we're getting off on something, and I need to focus on this. We'll come back to that." And I always do, cause again I know I can have them after the doctor's finished [my emphasis].

LS: Okay.

N5: So I've really learned a lot with interviewing skills. I find out precisely what the patient is expecting which is very important because sometimes it's like nothing and I know we're going to be throwing the book at them as a logical course of action for them. Or sometimes I think they're

expecting everything and I know probably just some palliative treatment is going to be what they're coming down the pike for. Um, or sometimes they are very accurate. They're very researched now. They know what they're going to be having as far as treatment--or they think they know, let me put it that way. Actually most often they're quite accurate, you know they are very informed. They've got the idea.

N5's view of herself as being "pretty good" is related to her ability to decipher the chart information and predict the course of treatment that will be offered to the patient. She uses this information to alert the patient prior to seeing the doctor about what might happen during the appointment. By "controlling" the interview, N5 suggests that she keeps the patients on track, but she also recognizes that the patients may want to discuss other concerns. By indicating that "she always comes back to that"[what the patient wants to discuss], N5 acknowledges that there may be concerns that fall outside those that she is trying to prepare him/her for. Controlling the interview at the first appointment, in effect, operates on the patient as a subject of discipline. The patient is expected to go along with the questions that are being asked and to only ask or speak outside these at a time signalled by the nurse.

N5's account of the role of the nurse during the first appointment is somewhat contradictory. On the one hand, she defines her specialty practice as based on knowledge about specific cancers. On the other hand, she signals that patients have concerns other than those that she typically addresses on the first appointment. N5 is unaware of the local knowledge that she draws upon to inform her practice. She points out an interesting feature of patients, that their priority needs may not be entirely predictable. The local knowledge of nurses is in the background and is not acknowledged by N5.

NL2, on the other hand, describes the nurse's role in the context of organizational and professional aims. Equating responsibility and accountability to standards resonates

with Foucault's (1991) concept of governmentality in that the manager governs the nurses' actions. In this case, they are "expected" to provide care in a manner that is consistent with the standards, but also in keeping with organizational expectations. Local knowledge is excluded by NL2. However, in order to more fully explore the knowledge that nurses take up in practice, an examination of practice in action is called for. I now turn to observations of a new patient appointment.

The following encounter occurred at Meadowview and while each new patient appointment was somewhat different, this encounter was chosen as it is somewhat typical of those I observed.

Preparations for the Clinic

Looking at the schedule

1245 N4: Clinic B – N4 is at the desk looking at the schedule for the afternoon, looking up, she says. It's going to be busy as there are three new patients at 1300 and only two nurses. Oh well, I have a plan that should work so that they all get seen properly. Turns her attention to several charts and begins thumbing through them. N4 indicates that she will have the doctor see the first new patient before she does and then she will follow up after the physician is finished with the patient.

N4: I hate doing things out of order, but there isn't anything you can do and he [first new patient] is likely a bit more straightforward than the next patient. Dr. Name is pretty flexible so this should work out okay. N4 briefly looks at the chart for the next patient.

Before the afternoon clinic begins, with three new patient appointments all scheduled for 1300, N4 has made a determination about how the work will get done. This necessitates making a change to the way things are usually done as she changes the usual order of seeing new patients. N4 gives an 'account' of her actions indicating that one patient is more straightforward than another and also that the physician is flexible. Garfinkel (1967) refers to 'accounting' for actions as a necessary aspect of membership, in this

case, as a member of the health care team. As a member N4 demonstrates discretion (cf. Garfinkel, 1967) in changing the usual practice of the clinic. Garfinkel suggests that members know when they should give an account of their actions and when they can be silent, and refers to this as “knowledgeability”.

Knowledgeability extends beyond the account that N4 makes and includes the local knowledge that N4 draws upon to exercise discretion. In the narratives of new patient visits, nurses account for practice as if it proceeds as they describe. This first segment illustrates that members [nurses] make changes to the ‘order’ of things, exercise discretion without apparent concern for sanctions from other members.

The First Appointment

The new patient appointment begins

1310 N4: From the desk, N4 calls a woman’s name. An elderly woman with oxygen per nasal prongs very slowly approaches the desk accompanied by a man of a similar age and a man about 35 years old. N4 escorts them into the small conference room at the far end of the clinic. Everyone takes a seat around the conference table. N4 turns to the woman. My name is [name] and I will be your nurse today. Do you think you have enough oxygen in your tank to last a couple of hours, as it will likely take that long?

Pt: Says something that N4 can’t decipher. So N4 turns to the two men.

Older man: The traffic was quite bad as there were a lot of lights out due to wind. And we will be going home in rush hour, so I don’t know.

N4: Yes, it was terrible last night wasn’t it. Well the reason I am asking, is if you don’t have that much in the tank after our chat I will take you into the exam room with oxygen in the wall, that way you can use ours instead of yours and chuckles.

Both men: Chuckle, sure!

Older man: My wife is Dutch and sometimes it is hard to understand her because of her accent.

N4: Sure that's fine. Could I ask who you are? **Turns to the younger man.**

Young man: Her son.

N4: Thanks, it is important to know who I am talking to. Could you tell me why you are here today and what you think is going to happen?

Husband: Well we have some idea, but would appreciate it if you could start from scratch.

N4: Okay, sure, we will go over everything. I am going to go over what you have put on this form and ask you a few more questions. Then the doctor will come in and examine you and then we will all get together to talk about what he thinks you might want to consider for a plan....Okay?

All: They all nod affirmative.

N4: **Looks at the form that they have filled out.** Maybe we could start by telling me what has happened before you got here? **N4 directs the question to the patient.**

Husband: Well, she had a spell before Xmas and went to hospital and they took some x-rays and found the spot on her lungs. **Patient nods affirmative.**

N4: Had you ever had any problems breathing before, any shortness of breath?

Patient: No, I never had any problems. **Her speech is heavily accented, slightly slurred, quiet, but discernible.**

Husband: Well, she had a collapse before Xmas and then she went into hospital.

Son: But her stroke turned out to have happened some time ago, so actually she couldn't catch her breath and that is actually what made her go to the hospital. **Husband nods affirmative.**

N4: So then in the hospital they took an x-ray and found a spot?

Husband: Yes, they did a biopsy and then she had an air bubble in her lung and they were worried. They said that they were thinking that they were going to have to put a tube in...we don't know what happened to the air bubble.

N4: Well I will make a note of that and make sure that the doctor has a good look at her x-rays and he will be able to tell you about that. How is your breathing now?

Patient: *Fine* [my emphasis]

N4: Do you take any medications?

Patient: No I just used to have a puffer, but since I was in hospital, I haven't had to use that at all, which is much better.

N4: So no other medications?

Patient: No.

N4: What would an average day look like? Can you tell me what you do?

Patient: Well I get up, not too early, get dressed, clean up...**gestures to her husband.** He cooks for me.

N4: So is that the same as before you went into the hospital, or about the same?

Patient: About the same.

Son: Well, mom, I'm not sure you are as energetic.

Patient: **Shrugs her shoulders.**

N4: Okay. How is your appetite?

Patient: Not bad.

N4: Do you think you have lost any weight?

Patient: I think maybe **and shrugs her shoulders.**

Son: I think her clothes are a bit baggier.

N5: Can you walk around the block?

Patient: Yes, but it would take awhile **and she chuckles as does her husband.**

N5: **Turns to the son.** Do you live close by?

Son: Yes, only about 3 minutes away from the folks.

N5: Are there any grand-kids?

Patient: Yes, two granddaughters, 9 and 12.

- N5:** That must be nice to have them so close.
- Son:** Yeah, it works out great. They get to spend lots of time with their grandparents.
- N5:** What do they think about this?
- Son:** Well we have had a lot of experience with hospitals as my daughter has Crohns disease [bowel disease].
- N4:** Let's talk a bit more about them after the doctor has examined your mom.
- N4:** **To the patient.** Do you work outside of the home?
- Patient:** Not anymore, I am retired, used to work at a grocery store.
- N4:** **To the husband.** Are you still working?
- Husband:** I am the maintenance man around the condo.
- N4:** Does your condo have any stairs?
- Patient:** No, we are on the first floor, no stairs.
- N4:** Well, that is all of my questions, I will take you down the hall to the exam room with the oxygen and the doctor will come in and examine you. You might want to have your husband stay with you while the doctor is there as sometimes it helps to have a couple of extra ears listening to what he is asking.
- Patient:** **Nods affirmative.**
- N4:** Do you have any questions about anything I have asked? I have made a note about your concern about the air bubble. Are there any other questions right now before you see the doctor?
- Patient:** No.
- Husband:** **Looks uncomfortable but says quietly.** Sometimes she is a bit confused.
- N4:** Well, sometimes that can be because of the lack of oxygen. So I will make sure that you get a chance to ask the doctor about that. Anything else? Then let's go down to the exam room. **N4 settles the patient and her husband into the exam room. The son goes to the waiting room.**

N4 hooks up the oxygen and assists patient to put on a gown and then N4 goes to the workroom at 1330.

Assessing patients

In this first part of the new patient appointment, N4 does a somewhat 'typical' assessment of the patient. The form that new patients fill out is quite lengthy and includes aspects of much of the information that N4 then goes on to ask the patient. As N5 indicated previously, the interview is 'controlled' or disciplined (cf. Foucault, 1977) by N4 who checks the form while she asks these additional questions. The questions she asks are instructive to the patient and family in relation to those things that are considered important in the clinic. Mitchell and Cody (1999) indicate that nursing assessments not only guide physiological care but also the type of relationship that nurses might have with patients depending on the type of questions that the nurse expects the patients to answer.

The nurses at Meadowview talk about doing a family assessment in addition to the regular questions that are on the assessment form. The idea apparently is to provide a more comprehensive picture of the patient in relation to his/her family in order to know what supports they have to draw upon (Fieldstein & Rait, 1992). However, I did not observe this type of assessment, nor could I envision what more this would add to the many questions that patients are already faced with in this first encounter.

N4 makes space for the concerns of the patient and her family, by asking, in the beginning and at the end, if there is anything that she hasn't asked about that they want covered by the physician. The husband mentions the air bubble, and, although N4 makes a note of it, she does not ask any questions about it. The lack of further discussion about the air bubble by N4, further instructs the patient and family about the place for such 'other' concerns-- that is to ask the physician.

The patient and her family 'go along' with the interview format as I suggest that they have a disciplined understanding of how to be a patient, perhaps in part based on their recent hospital experience. I argue that understanding the role of the patient is a composite of many influences such as previous personal experience, stories of others, media, and so on. These influences also include a depiction of the health care provider as expert. As previously discussed, setting themselves up as experts, nurses position themselves as having knowledge about the patient, rather than the patient having knowledge about him/herself. The disciplining affects of the cancer clinic assessment form and accompanying questions produces very clear ways in which patients are expected to behave. This is another example of governmentality in line with Foucault (1991) as the practices of the clinic govern both nurses and patient behaviors.

There is a contradiction with this disciplined understanding of being a patient and how self-help literature instructs patients. Patients are instructed to take control of their lives and become participants in their own care (Cotter, 1999). In the observational materials that included numerous new patient appointments, I did not encounter a new patient or family taking control. The depiction noted above was somewhat typical of how patient/families behaved on their first appointment. I believe that an uncritical read of patient self-help literature is decontextualized in a way similar to that of the so-called professional literature. Therefore setting up expectations of patient behavior, without considering the context in which that behavior is to be enacted, is remarkably similar to expecting all nurses to do all things nursing according to prescriptive standards.

The New Patient Appointment – Part Two

Reporting in

N4 goes from the patient exam room into the work area and greets the physician who will be examining the patient that she has just seen.

N4: Hi, [first name], are you ready to hear about Mrs. [name]?

Dr: Looks up from the patient's chart. Sure.

N4: Well it seems that she was essentially healthy before this episode in December. Kind of hard to know what happened. Some mention of a stroke, but apparently she also had some breathing difficulties. Anyhow, she went to hospital and, as part of her workup, they did an x-ray, and found a tumor. She is retired, has lost a bit of weight, lives with her husband in a first floor condo. Her son lives nearby. Her husband is worried about an air bubble that apparently showed up on the x-ray after her biopsy. She is a bit difficult to understand, has an accent. I'm not actually sure if she understands everything that is going on. Her husband says she is a bit confused, so you might want to check that out.

Dr: Okay, I will check that out. Might be that her oxygen needs to be increased.

N4: Yep, I mentioned that to her husband, but you could reinforce that or it might be something else. I think I will make a home care referral. By looking at this [pathology report] and at their ages, they are likely going to need some help, so likely should have someone get to know them now.

Dr: Sounds like a good idea, as her x-rays look pretty bleak. I will mention home care if I get a chance. If not remind me. I'll go in and examine her and I will call you when I am done so that you can join me. **He goes into the exam room at 1335.**

Giving an account of the patient interview to the physician was discussed in Chapter Seven. In contrast to what was discussed previously, in this encounter, the physician also participates and adds to the discussion. It is not all one way. N4 refers to the pathology report and the age of the patient to make the inference that help will be required at home in the future. The physician concurs by adding information about the x-ray. Together they do more than share information. For example, the nurse indicates that the physician should follow up on the patient's cognition, and he agrees to do so.

Duplicating efforts

One of the goals of care in the organizational change was that there would not be unnecessary duplication. One of the strategies to mitigate unnecessary overlap in care was the development of the patient referral-care-discharge process. This process depicted who should see the patient, when, and what s/he should do. However, as the above encounter illustrates, patients do not necessarily lend themselves to being 'mapped' along a process. The overlaps in assessment and questions asked by N4 and the physician, supplemented by the assessment form that has already been filled, out are meant to reinforce information for the patient. None of this duplication and overlap appears to burden the family or cause undue hardship to the running of the clinic. A map of the new patient appointment assumes that people will follow a linear path with no need to retrace their steps. But, as described by Cotter (1999), it might be argued that on the first patient appointment, overlap and duplication might actually benefit the patient due to the highly charged nature of this appointment.

Getting along with the physician

Pippy (2001) indicates that a nurse's ability to control the triage of patients [referral to others] "seemed contingent upon the unique practices of individual physicians, as opposed to cancer center standards for medical care" (p. 122). Pippy goes on to say that nurses in her study changed their approach depending on the particular physician that they were working with. She suggests that 'knowing the physician' was integral to developing a positive relationship. I suggest that 'knowing the physician' is but one of the knowledges that the nurse brings to the clinic. In the same fashion, the

physician must 'know' the nurse in order to build a relationship or partnership that, according to the Patient Care Change Team (1996), requires mutual respect. In the context of practice, the nurse must 'know' about more than just the physician. Previously I advanced an argument that nurses draw upon their local knowledge in caring for their patient. Knowledge about the physician is one, albeit an important knowledge.

The Appointment Continues - Part Three

Patient/family conference

1400 **The physician comes into the work area where N4 is documenting information on a chart and indicates that he is ready to talk to the patient and family about her cancer. He has not been able to find the CT scan report and asks the clerk to see if she can get a copy of the films and the report. We all go into the exam room where the patient, husband and son are sitting on chairs, waiting. We each take a seat and the physician begins.**

Dr: N4 and I have both had a chance to ask you some questions and I have examined you, so now we would like to talk to you about what I think might be going on.

All: **Nod affirmatively.**

Dr: You have a tumor on your right lung that they found when you were in hospital at Xmas. You have had some other tests to try and find out if there is anything else going on. Your bone scan didn't show any signs of cancer anywhere else which is a very good thing. There are several ways this kind of cancer can be treated. The first is by surgery, but that may not be an option as your tumor is quite big and, if they try and take it out, it would leave you with not enough lung, and your breathing would really be difficult. Are you following me so far?

All: **Nod affirmatively.**

Dr: So, it is unlikely that surgery would be called for, as it would leave you incapacitated. In terms of chemotherapy, again it is my opinion that the side effects would outweigh any benefit that you would gain. **He pauses and looks at the three of them.**

Son: So mom has a large tumor.

Dr: Yes she does. It is my advice to try some radiation. I would suggest five treatments over five days. So one week. Sometimes we do more, but then you can get into trouble with damage to the lung that can impact your breathing when what we are trying to do is reduce the tumor to improve your breathing.

Patient: Is there a chance that the tumor will shrink?

Dr: Well, that is what we will be hoping for with this kind of approach. After the five treatments, we will do a follow up at six weeks. If you are feeling okay, then you can be followed by your family doctor. Any questions?

Patient: What happens with the radiation?

Dr: In the short term not much at first, then you can feel tired, need to sleep more. You can have irritation of the lungs, that means you might have a cough. Some people have some phlegm and some trouble swallowing. Some people lose their appetite. Where the radiation is, your skin can get itchy and a bit irritated and red. You might have all of these or none of these. You just can't tell, as it is very individual.

N4: If any of these things happen, we are here to help you manage them.

Patient: Well that doesn't sound too bad, but..

Dr: In the long term you might have some scar tissue in the chest that might affect your breathing, or your food pipe might be affected which could cause some swallowing problems. But you don't see these types of problems for 3-4 years and I don't think that will be something that you need to worry about.

Son: So what is the time that we are looking at?

Dr: I don't really know, we don't tend to look for problems. Some patients do fine with the radiation and we don't see them for a while. So we are looking to improve quality of life, make your breathing easier, but it is not curative. There is not a cure for this. But to get back to your question, it won't be years, not weeks, but certainly not years. The treatment will not change that. This is a type of cancer that very well may have already spread or it will stay where it is for a while...hard to tell.

Son: So what, what, um happens when things happen.

Dr: It is hard to tell, as it all depends on how your mom feels. If she has a problem, say with her hip, then we would have a look and see what the

problem was and what we could do. But we won't be doing a bunch of tests looking for problems. Any other questions?

Patient: When would I start?

Dr: As soon as I can set it up. In the next two weeks or so...anything else?

All: No.

N4: What about the air bubble?

Husband: Oh yeah!

Dr: By the look of the x-rays it is slowly going away. It has done no harm and will not interfere with the treatments. If there is nothing else, I will leave you with N4 to go over any other concerns you might have. **He gets up and shakes hands with them all.** See you in a week or two. **Leaves the room at 1430.**

Words unsaid

In this part of the visit the physician reviews with the patient and family what the possible treatment options are and his opinion. They are told that radiation treatment is not a cure and that it is intended to help with her breathing. The side effects are briefly discussed with the proviso that each person's experience is different. None of the family or the patient question the idea that the radiation is going to help with her breathing, particularly as the patient has indicated that her breathing is fine.

The physician mentions that the most severe side effects of the radiation occur after "3-4 years." He further indicates that this is not something that the patient needs to worry about. The son pointed asks "so what is the time that we are looking at?" The physician equivocates somewhat, but indicates that it is somewhere between weeks and years. Throughout his explanation, the group listened intently but, except for the son's query about the time remaining, they did not visibly react to any of the information. At

this point in the appointment, it would be difficult to ascertain what impact the information has had on this family. I suggest that there has been as much unsaid as there has been said during the time with the physician.

Any questions?

N4: So that is a lot of information. I have written down the points that Dr. [name] discussed with you so you can take it with you, as you might want to go over it again. Are there any things you would like to go over now.

Patient: I'm not sure.

Husband: Can we talk about *what might happen with the radiation?*[my emphasis].

N4: Sure, first off, the doctor said that you have a large tumor that would be difficult to deal with by surgery or giving you drugs or chemotherapy. Secondly he suggests five days of radiation with the goal of shrinking the tumor and helping you breathe a bit more easily. It is his opinion that this is the treatment of choice, but it is up to you.

All: Nod affirmatively.

N4: Then he mentioned that you might have some side effects, itchy skin, swallowing problems or dry mouth, but you also might not. If you have any of these problems *we will help you with them*. If things go well you would come back to see us after six weeks and then continue to see your family doctor. You would only have to come back if you had any other problems [my emphasis].

Son: The doctor mentioned maybe getting some home care, what do you think?

N4: I think it is a good idea. All it means is that the home care nurse will make a home visit and see if she can be of any help. She might have some tips about how things are arranged at home that might help you conserve your energy. It gives you a chance to get to know them and, if you need them, they will be available.

Husband: I will give you my cell phone number, so they can call me to arrange a visit. I always have it on in case she (points to his wife) needs me.

N4: Anything else?

- Son:** I wish my sister had been here. She had to go back to England yesterday and I want to make sure that I fill her in accurately. I am sure she would have some questions.
- N4:** Well, I will give you my card with my phone number and email address. So she can phone me or email me and I will give her the information from today and, if she has any questions, I will make sure they are answered.
- Son:** That would be great, as I know I will forget something.
- N4:** Well, hopefully, these notes might help and if you have questions, you can call me or email, and I will be pleased to get back to you. Anything else?
- All:** No.
- N4:** Then let's get you hooked back up to your oxygen tank and I will put all of this information in a folder for you, with your card. I will take you around and show you where the radiation department is, so that you will know where to go on your first appointment. **N4 changes over the oxygen and we all walk out to the desk area. N4 photocopies the notes she has taken in the folder along with pamphlet about radiation. Turning to the son she mentions,** If you find that your children have any questions that you are not sure how to answer, we run a children's program here that others have found helpful.
- Son:** That sounds like it might help, and **he takes the pamphlet that describes the program.**
- N4:** **Takes the patient/family on a short tour of the radiation area, pointing out where they register, where the waiting area is, where they change. During the tour, N4 indicates the other services that are available, a nutritionist, a counselor and volunteer drivers if they ever have problems getting to the clinic.** I have put an information sheet in your folder so that when you have time, you can refer to the services that we can provide. They have wonderful relaxation classes that are very helpful for people that have problems with their breathing and, of course, your husband would be welcome also.
- Son:** Quietly to N4, I just want to make sure she has good quality of life.
- N4:** So do we, and if you ever have any concerns about how that is going, you need to let us know, as this is all about her quality of life. **The tour finishes and N4 and the group are at the front door.** Any last questions before you go?
- All:** No.

- N4:** Okay then, *you have a lot to think about*. Please give me a call tomorrow, or whenever, if you have any other questions. Bye for now. [my emphasis].
- N4:** **Returns to the clinic area at 1455 and documents on the chart, places her notes from the meeting with physician on the chart, makes out a home care referral form and says to me.** I will call the home care later and give them a report. I find that they are more receptive that way, as they seem to get antsy when they have a cancer referral. I find if I make contact then if they have any trouble, they will call us and we can give them a hand. **She finishes her charting and then goes on to see the next patients.**

In this final encounter during the new patient appointment the value of duplication and overlap becomes apparent. The nurse is able to reinforce and interpret or reinterpret the information that the physician has provided. Her written notes provide information for the patient/family to take home, so that they are not relying on their memory to keep track of what was said. All of these strategies are in keeping with what patients have indicated is important to them in terms of obtaining information (Fitch et al., 2002).

It is not difficult to appreciate that patients experience information overload, given the amount and very serious nature of the information that this family was given during their appointment. It is not difficult to think that they would not remember all that was said to them. An information folder and offer of a follow up phone call also provides the family with another opportunity to ask questions that may occur to them once they are at home. The offer of answering questions that the sister might have also relieves the family from having to 'tell the story' when they themselves are trying to understand what they have been told. However, in this encounter, which bears many similarities with other new patient appointments I observed, there is much left unsaid. I suggest that as 'specialists' working in the clinic, nurses are constrained by the oncology knowledge that

they draw upon that does not leave them open to 'hearing' the needs of individual patients. I will discuss this further in the final chapter.

The entire new patient appointment took approximately 2 hours, and N4 spent approximately one hour of that time with this patient and her family. In the time when she was not with this patient, she was seeing follow-up patients or the other new patient. N4 was able to choreograph the afternoon in such a way that, as I observed, she did not appear rushed with any of the patients. She had reviewed the patient list and discussed with the three physicians which follow up patients might require some nursing care and which patients only needed to see the physician. I argue that this way of 'managing' the clinic requires more than having a good relationship with the patient. N4 was able to negotiate time and space with the physicians in the same way that she negotiated time with the patients. Drawing on her oncology knowledge, local knowledge about the physicians, clinic operations and others [such as home care] N4 was able to enact her practice in a way that appeared to meet the immediate needs of the new patient depicted in this encounter.

Summary

Oncology nurses are faced with contradictory information about their role from academia, organizational processes, and nurse leaders. They are instructed to think of patients as having both physical and psychosocial components and yet patients, on their first appointment at the cancer clinic, present as whole beings. The patient's perspective is portrayed in a linear manner by the professional literature and is incongruent with the self-help literature.

Faced with these competing aims, nurses on the first appointment draw upon their local knowledges to negotiate time and space to care for patients. They are able to skate between the organizational processes, partly in relationship with other 'members' of the health care team. They are untroubled by how their actions might contradict the organizational change aims and their actions appear effortless in their practice. The new patient appointment parallels to some extent the processes laid out in the patient care changes. I suggest, however, that where organizational aims contradicted the local practices of the nurse, (for example, in overlap with the physician), that these practices were not taken up. In the final chapter, I will further explore the knowledges that oncology nurses draw upon in their specialty practice and how this affects their ability to meet the goal of providing individualized care to patients. I will comment on the impact of the organizational change observed in this study, and suggest how I as a nurse leader will make use of this information.

Chapter Nine: Summary and Discussion

It is much more important to know
what sort of patient has the disease
than what sort of disease the patient has.

Sir William Osler, MD (1892)

Introduction

Against a backdrop of a significant organizational change initiative, this study was concerned with an examination of oncology nursing practice primarily in the ambulatory care setting. Health care organizations in Canada have been in a perpetual change mode since the early 1990s. The organizational change initiative in this study provides a powerful case study to examine the effects a change of this magnitude has had on everyday nursing practice, particularly as one of the main objectives of the change was to implement a new patient care team.

Nurse leaders are often called upon to make changes in practice based upon the goals of their particular organization or other external forces, for example governmental policy. As a nurse leader who is expected to respond to these forces and make changes in practice, I was interested in gaining new insights into practice that would inform my current understandings, and my ability to decide wisely.

This study involved an in-depth examination of oncology nursing practice in two ambulatory settings in Canada. This examination involved observations of the work of nurses. Field notes were crosschecked with interviews with the observed nurses and nurse leaders. Organizational materials particularly related to the change initiative served as a secondary source of crosschecking with my observations, and the narratives of nurses. The interpretation of the nurses' work is based on critical theory. The examination resulted in a contextualized reading of oncology nursing practice.

My reading suggests that although the goals of the organizational change initiative were contradictory, nurses have not problematized these contradictions. In their narratives they hold up the importance of attending to the specific needs of patients while at the same time enacting a practice that, for the most part, demonstrates the goal of efficiency. The dominance of the “schedule” and “routines” in my observations is contradicted by the ability of nurses to work outside of these bounds. Working outside of the schedule goes virtually unnoticed by other nurses, physicians or patients. Yet, nurses talk about not having enough time with patients.

Nurses in this study talk about their practice guided by what I have argued are contradictory theoretical frames, including the organizationally espoused model of Primary Nursing. In Chapter Seven, N3 indicates that at Brookline, they were not able to implement the primary care model, and yet, in my observations the practices are remarkably similar across both study clinics. Observations did not reveal a discernible model of care, for example primary care, but did reveal a predominant reliance on disease-related knowledge.

In explicating the expert nature of her knowledge, N5 indicates those areas that she is “pretty good” in and these relate to the technical knowledge about specific diseases. Opportunities to draw upon other knowledges are not taken up, perhaps most blatantly illustrated in the first patient appointment, where knowledge outside of the technical rational was seemingly not part of N4’s repertoire. Yet N4 mentions that it is “interesting” that what is important to patients is often not what she or other health care practitioners predict.

Knowledge about individual patients appears to be unimportant as depicted in the first patient appointment. Nurses acknowledge the importance of supportive care, yet support in the context of how it is articulated as a therapeutic intervention by Carroll-Johnson, Gorman & Bush (1998) was very rarely observed during my study. That is not to say that the nurses did not demonstrate a warm and caring attitude on easing the patient's way through the system, even while they attended to the technical aspects of care.

Nurse leaders provided different perspectives of life in the clinic. Everything from how the day starts, to articulating the role of the nurse, their views were somewhat different from that of the nurses. These differing perspectives may in part be related to the invisibility of much of the work in the ambulatory clinics. The visible aspects of the work are only apparent to those who are present in the clinic setting such as other nurses, physicians and clerks. The ability of the nurse leaders to 'know' what is going on in the clinic involves attention to proxies such as timeliness, patient feedback, physician feedback, and so on. Thus, it is not difficult to understand how changes to practice may not be implemented as envisioned, as there is little congruence between the nurse leaders and the nurses on how practice proceeds in the everyday. How then do I, as a nurse leader, approach changes in the future?

I will now highlight the major themes arising from this reading of oncology practice and how I, as a nurse leader, will make use of them.

Organizational Themes

The contradictions in the espoused role of the primary nurse and the day-to-day enactment of practice were evident in comparing nurses' narratives with observations of

their interactions with patients. For example, in Chapter Seven, N4 provides an image of the primary nurse that is consistent with primary oncology workshop information materials. She describes the role of the nurse as supporting patients throughout the cancer experience. However, in observing N4 with her patients, it is evident that she is following a prescribed process that appears focused on moving patients through the system rather than focusing on individual patient needs. The incongruence in the description of practice and the observations of practice are discussed in Chapters Six, Seven and Eight.

Organizational Change(s)

Team re-configurations

Suggestions for changes in health care practices are rampant today in the context of the almost continuous restructuring of the health care system. In this study I have attempted to identify the impact on nursing practice of one organizational change initiative that was designed to improve care to cancer patients, and at the same time gain efficiencies in care processes. In attempting to assess the impact of these changes, I carefully examined the underlying organisational assumptions associated with changes to the nursing role at the two cancer clinics. One of the focuses of the organizational change was to develop a patient care team consisting of an oncologist, a nurse, a secretary, and a patient information coordinator. The role of the nurse was intended, in part, to provide a consistent person for patients to interact with as they moved through the various aspects of care and treatment at the cancer clinics. A new role description was developed for the primary oncology nurse (PON), and workshops related to the changes in the role were provided for nurses who would be working in the ambulatory clinics.

As discussed in Chapter Three, there are contradictions in the organisational role description and the workshop information that was provided to nurses regarding primary nursing. The written role description emphasises the importance of the nurse following standardized processes, and the workshop information stresses the importance of focusing on patients and wellness. Observational materials reveal an emphasis on running the clinics efficiently and moving the patients through their clinic appointments in a standardized manner.

The nurses in the study did not appear aware of the contradictory aims of the organizational materials that were used to shape their role. In Chapter Seven, nurses at Meadowview describe their role as PON, and their description match the discourses espoused in the organizational change documents. The nurses at Brookline suggest that primary nursing was not implemented as envisioned. One of the main reasons given by the nurses is that there were not enough nurses to assign to the physicians and, therefore, primary nursing would not work. This explanation is consistent with the changes that were occurring at Meadowview due to increasing volumes of patients. However, this reason for not implementing the PON model, reduces the vision of the PON to one of workload rather than a model of care designed to ensure consistency for patients.

One of the questions that frame this study asks how, within a contextualized understanding of practice, a leader knows that practice is being changed or improved and what might account for such change/improvement? I suggest that the explanation of increasing workload is too simplistic for the lack of success of the primary nursing model at Brookline. Although the organisational change was intended to span two clinic settings, the local context of each of the settings is quite different. Thus the reasons for

success or failure must be explored in the context of the two clinic settings, not just at the macro organisational level.

Change management

Copnell (1998) examines many of the prevailing views of change and concludes that “within nursing a rationalist view of change predominates” (p. 6). Change is seen as logical, inevitable, and desirable. If change is “unsuccessful, fault can be seen to lie with the targets (because they are irrational), the change agent (whose efforts have been ineffective), or with the strategy or theory” (p. 5). However, in examining reasons for what might contribute to unsuccessful change, the reason for the change itself is not questioned. Typically, the aims of change such as the one in this study would not be examined and therefore the contradictory nature of aims would not be revealed.

As part of the organizational change initiative, a Change Management Team was formed to “facilitate the human side of change” (Change Management Team, 1996, p. i). In the 1996 report of this team, change is described in the following manner,

- Change is a threat when it is done to me!
- Change is an opportunity when I do it!
- Response to change is intensely personal!
- Successful organizational change must engage the imagination of all in the organization! (p. 1).

The organizational and administrative discourses related to change are revealed in these descriptors. Following a rationalist view of change, I might, as a leader, construe that the lack of implementation of the PON role at Brookline was due to nursing staff being resistant to the change, or that the leaders at Brookline, the change agents, were ineffective, or that the implementation strategy itself was flawed.

Copnell (1998) suggests, “organizational and administrative discourses help shape the way in which change is understood... change is not context free” (p. 6). Although the change initiative occurred in the context of a large cancer organization sharing many similar processes and discourses, each of the clinics also has a local organizational context. Therefore, rather than attempting to understand why the change did not occur at Brookline, I suggest the organisational and administrative discourses at each of the clinics were quite different, and thus shaped the way in which the organizational change was construed, understood, and ultimately implemented. Further, Munro (1998, 1999) suggests that organizational change and managerial discourses serve to create a language and culture that frame the way changes are viewed, and talked about. In the case of Meadowview, nurses took up the change initiative language and ethos, and at Brookline they appear to have continued what they were doing earlier. In both cases the nurses align themselves with the practices in their respective clinics rather than with the larger organization or indeed the larger group of nurses. Accounting for changes, then, becomes a matter of understanding the organizational or, in this case, the clinical context in which the changes were meant to occur.

Accounting for Changes

Membership

In Chapter Seven, following Garfinkel (1967), I discussed the concept of membership and argued that the nurses account for their actions and, as part of mutual surveillance, they are also called upon to affirm or sanction the accounts of others. In order to do this, members need to ‘know’ when each action is warranted. Garfinkel refers to this as knowledgeability and suggests that members demonstrate a competence

in knowing how and in what circumstances to affirm or sanction accounts. This organizational change disrupted the local circumstances and the knowledgeability of members. Membership itself was called into question as the change necessitated a re-design of the patient care team and new roles for various members.

Although the nurses at Brookline point to workload as the reason for not implementing the PON role, their narratives also reflect a concern about how their membership was threatened by this type of change. For example, in Chapter Seven, N6 and N3 comment that they had been a “cohesive group” and were “pushed and shoved out of the way with our whole idea about the team concept” when the concept of primary nursing came to the forefront. They indicate that their idea of ‘team’ was supposed to be set aside in favour of the ‘new team’ concept elucidated by the change initiative. In addition, one of the nurse leaders at Brookline indicates that it is not important to “get hung up on primary nursing” (NL2). She goes on to suggest that it “doesn’t matter if you’re a primary nursing model or a site team model or a collaborative or team model, it doesn’t really matter... it is the principles that need to be in any model of nursing.” These statements suggest that somehow nurses practise in a manner divorced from the practices of others. I suggest that it does matter how the work is constructed and enacted, as the relationship with the practices of other team members will affect how care can be carried out. Whatever the principles of nursing are, they are practiced in ‘routine ways’ in the context of other health care team members, and of the patients and families.

Belonging

In an exploration of the impact of market discourses on private sector institutions, Munro (1998) examines how organizational changes affect the process of belonging or

affiliation. In order to 'move forward, the current affiliations must be disrupted and new affiliations developed. This disruption necessitates what he refers to as "rubbishing the past" (p. 220). In other words, in order to achieve a new way of thinking about the organization, the old ways must be construed as outmoded, out of sync, belonging in the past, and not capable of sustainability in the future. In this change initiative, the strategic repositioning of the organization was seen as essential and characterized as 'urgent' as the organization was thought to be in jeopardy in relation to other provincial changes in the health care environment.

Key features were identified that were deemed as "obstacles to moving from being a good organization to one of world-class excellence" (Cancer Agency, 1995, p. 6). One of the features deemed essential was "moving the delivery of care and services from being departmentally organized, to key processes incorporated into large provincial programs" (p. 6). The rationale for this change was to improve the quality of care to patients and families by creating systems for "seamless delivery of care with a minimum of hand-offs" (p. 6).

Although patient care is supposed to benefit from this change, the rest of the report discusses changes to what I consider managerial focused issues, such as finance, roles, accountability, and so on. What the change to a program type delivery system did in effect, was dismantle the department of nursing. It disrupted nurses' affiliation with their collegial group and aligned the nursing staff with systemic therapy, radiation therapy, or surgical oncology programs. The leaders of each of these programs are physicians. The nurses no longer belong to a department of nursing and are assigned to one of the programs. Several nurse leader positions were deleted in the process.

Cohen (1982) examines the experience of belonging and culture in the British Isles. His explorations suggest that although the state as a whole share many common features, individual places are highly particular, and within the “boundaries of commonality meaning is shared and communicated in idiom and social organizations” (p. 9). In examining local cultures, Cohen cautions researchers to distinguish between the “locality’s voice to the outside world, and its more complicated messages to its own members” (p. 8). He goes on to suggest that members simplify their messaging to those on the outside as it is simpler than trying to explain the multiple complexities of a particular social setting such as a village. Similarly, I argue that the nurses account for their practice in simplistic terms that should not be taken as the totality of practice. I further contend that in simplifying their accounts of how they deliver care, the change team may, as Cohen suggests, have treated this simplification as an accurate account of practice, and used it as a formulaic key to unlocking the mysteries of the organization (cf. Cohen, 1982).

Although Cohen’s focus was on the variety of social cultures within the British Isles, I argue that his findings regarding the heterogeneity of Britain resonates with the findings in this study. The nurses at each of the clinics belong to a culture, that while interrelated at the larger organizational level, and sharing many common influences such as economics, technology, and policies, is still separate and unique. There are also many differences at the local level in the individual clinics. Cohen suggests that the powerful ties to the state, or in this case the larger organization, “may present powerful constraints, but they do not determine form” (p. 12). In other words, the ties that each clinic has to the larger organization may mediate some of their actions in relation to the change

initiative but cannot determine how it is that they will enact these changes in the everyday.

Munro (1998) indicates that reconfiguring or redefining affiliations influences the surveillance and sanctioning of everyday accounts of practice. He suggests that when affiliations change, how we come to account for our practice likewise changes as our relationships or membership has also shifted. Nurses at Meadowview align their accounts with the new team roles and articulate their practice in the language of the Patient Care Change Team, for example Primary Nursing. At Brookline, the nurses aligned with what had been their site teams and continue to account for their practice in the language of these sites, for example they might describe themselves as ‘a breast site nurse’.

Cohen (1982) maintains that cultural boundaries are not “natural phenomena” (p. 9). These can be ignored or adhered to by those who belong, and for different purposes. Thus, it is not incongruent for the nurses at the clinics to identify themselves as Registered Nurses, perhaps as a BSN, Oncology Nurses, a Cancer Clinic Nurse, a Systemic Therapy Nurse, a Site Team Nurse, and so on. Cohen argues that at an ascending level, self-identification is simplified, such as being a Registered Nurse, and at a descending level as one comes closer to describing belonging to a locality such as the clinic, the message is much more specific and complex. He further indicates, “belonging to a locality far from being a parochial triviality, is very much more of a cultural reality than is association with gross region or nation” (p. 10). In this study, I argue that the nurses while identifying with, for example, the Canadian Association of Oncology

Nurses (CANO), much more closely align themselves and their practice with the programs to which they are assigned, and the locality of the clinic that they work in.

Implications

The nurses' accounts of practice cannot be taken to represent that practice. Latimer (1993), following Garfinkel, states "their accounts may tell a great deal about ethos, rules, beliefs, values, nurses discourse, and the construction of reality, but may not be taken to tell very much about how practice is practiced, because frequently what we do, and the reflexive recall of what we did are different" (p. 314). One of the first steps in the change initiative was to map out all of the steps in the care process. This entailed a very detailed examination of the path that the patient takes as he/she moves through the various aspects of an appointment. The mapping process was based on the accounts of the health care providers on the team. I suggest that re-designing the care process based on the accounts of providers was fundamentally flawed as these recollections may or may not have represented how practice occurred in the everyday.

This study provides many examples of the mismatch between how nurses talk about their practice and how their practice was observed to proceed. Thus, it is essential for leaders to understand that accounts of practice are representations and cannot necessarily be taken to represent what occurred. Nurses do not practice in a vacuum. As noted previously, membership and belonging are essential features of everyday work life. Nurse leaders should not underestimate the importance of 'belonging' at the local level, as this may be dominant to belonging to the larger family of nursing.

Basing changes solely on accounts does not take into consideration many of the features of the contexts in which practice proceeds. Although the nurses in this study talk

very differently about practice, my observations revealed remarkably similar practices in both clinics. This suggests to me that there are very strong structures, or organizational processes, in place that influence how practice is enacted. Without identifying the structures and processes that wield such a powerful influence it is hard to imagine that any type of change would actually take hold.

Nurse leaders interested in making changes in practice need to understand how organizational structures mediate opportunities to practice differently. Changes need to be designed that take into account the many features of the workplace, and that reflect an examination of that workplace. Time spent in gathering accounts should also be spent in observing practices. In order to ascertain whether a change has been successful, the changes must be based on understandings of practice that go beyond descriptors.

Measures of success also need to be considered in a contextualized manner. My observations and the narratives of the participant nurses inform my interpretation on the success of the change initiative. Several of the change aims do not appear to have been achieved, such as flexible scheduling, and the role of the PON. Several of the efficiency goals such as the smooth running of the clinics are apparent. As it is not clear to me how the pre-change 'map of practice' was depicted, it is not possible for me to understand what aspects of nursing care provision actually changed. However, if called upon to account for the current oncology nursing practice in relation to the change initiative, I would point to the organizational structures such as the site teams, assignments, and schedules as the major influences on how practice is enacted in the everyday.

As I consider how I will approach the recommendations suggested by the CNAC report, I realize that it will take more than good ideas to actually make changes in the

practice setting. Based on this study, one of the key recommendations from CNAC that may resonate with the nursing staff is related to having sufficient numbers of staff to meet the complex needs of patients. However, I am not inclined to respond to the recommendations in a manner that presupposes that changes to practice will occur. Rather, I will use this study to engage the ambulatory nurses in a dialogue about their practice in the hopes of deepening their awareness of how practice is observed to proceed in the clinics before we talk about making any changes based on the CNAC recommendations.

Any change suggestions that the nurses identify must also be discussed at length with others that work in the ambulatory setting. This study illustrates the strong connection between physician and nurses' practices. Any changes that occur in the nurses' practice necessitate a change or shift in the way that the physicians do their work. For example, taking the nurses out of the 'patient relay' in the ambulatory clinics would shift many of the established processes, and the structures that support these. At this point I am thinking that rather than embarking on any type of major change, we might build on those practices that I observed that meet the spirit of the CNAC recommendation. For example, the nurses at Meadowview are already engaged in discussions about making modifications in their clinic practices as the numbers of patients continue to outstrip the existing resources. These discussions and potential changes align with the CNAC recommendation about workload. The important difference is that, rather than having the CNAC recommendations drive changes, local circumstances will determine if the recommendations apply and then if changes are necessary.

Another consideration that must be considered when contemplating a change, is the potential shift in membership or belonging that might result. The nurses at Brookline viewed the change initiative as taking something away that was working well--their teams. Any change to how the nurses work in the ambulatory clinics must take into consideration how belonging can be maintained or shifted in a way that is acceptable to the staff.

Expectations – Individualized or Standardized Care

Individualized care

The quote at the beginning of the chapter is reflective of an ethos that oncology nurses are subjected to in the oncology literature, in the CANO standards, and in the organizational change aims. Cotter (1999) suggests that “everyone’s experience with cancer is unique...each having their own personal journey” (p. 109). Nurses are encouraged to provide ‘holistic’ care to their patients. Nurses, guided by the CANO standards, are encouraged to do a thorough assessment of each patient in order to identify their needs, problems, and then develop a plan of care that will address these. The organizational change initiative guided nurses to address the specific needs of patients, and strive to be the consistent health care provider as patients move through the various aspects of their cancer treatments.

There were few observational examples in my study that pointed to an individualized plan of care. In Chapter Six, N1 is shown to work outside of the schedule, taking a great deal of time with a patient who is extremely distressed. Neither N1 nor any of the other clinic staff remark on the extra time taken with the patient, individualized care is not mentioned, and nor does this particular event appear to interfere with the way

the clinic operations ran. Comments about individualized care are threaded throughout the narratives of the nurses. N5 describes the importance of understanding what it is that the patient is most concerned about on their first visit. She then goes on to explain that given that she knows what they are going to get, it is her role to “prime them for things” [to come]. The apparent contradictions in these two statements appear invisible to N5. One explanation may be that the practices in the clinic are also framed against a backdrop of contradictory aims.

Pippy (2001) suggests in her study that the nurses’ work “seemed to be focused on getting patients through the cancer system quickly” (p. 161). That is congruent with the findings in my study. For example, N4 provides an image of the primary nurse that is consistent with the workshop information materials. She describes the role of the nurse as supporting the patient throughout their cancer experience. However, in observing N4 with her patients, it is evident that she is following a prescribed process that appears focused on moving patients through the system rather than focusing on individual patient needs. Pippy goes on to suggest that nurses have more to contribute to oncology patients, and the organization of ambulatory care needs to change in order to facilitate that contribution. I suggest that before an organization embarks on yet another change in ambulatory care, we must first attempt to clarify how the conceptualization of standardized care either complements or impedes the goal of individualized care.

Standardized care

According to the Canadian Strategy for Cancer Control (CSCC) (2002), the number of Canadians diagnosed with cancer each year is steadily rising in part due to population growth and aging. It is anticipated that these two factors combined could, by

2015, result in an increase in the number of new cases 70% greater than that at present. As newer drugs and technologies have arisen, patients are surviving longer and the prevalence rates are estimated to be three times higher than the incidence rates. In 1998, cancer cost Canadians approximately \$14.5 billion, \$2.8 billion in direct costs and \$11.7 billion in indirect costs (CSCC, 2002, p. 5). Given the anticipated increases in cases, these costs are expected to escalate in the next decade.

According to the nurses and nurse leaders at Meadowview, one of the reasons that the role of the PON had to be changed from what was originally envisioned in the change initiative was due to the increasing numbers of patients. They were apparently no longer able to sustain a model of care that paired nurses with physicians' patients, as there were too many patients that needed to be seen. If, as Pippy suggests, there is a greater contribution that nurses could be making in the lives of ambulatory care patients, then this contribution must be held up against the anticipated numbers of patients that require care.

As discussed in Chapters Six and Seven, although the CANO standards point out the importance of individualized patient needs, they do so in the frame of a standardized approach. Nurses are guided to assess, plan, intervene, and evaluate care in a rather prescriptive manner. These standards presuppose that all patients approach their disease in a similar manner. Rather than opening up the uniqueness of each person, I have argued that this approach negates the unique features of patients and suggests that patients follow a predictable course, as if individual context does not impact how it is they will react to their cancer diagnosis.

The CSCC (2002) points out the enormity of the burden that a cancer diagnosis can have on a patient and family. In the priorities for action document, it is suggested, “no amount of surveillance or analysis can quantify the grief and suffering of cancer patients, survivors, and their families and friends” (p. 6). While identifying the individual impact of a cancer diagnosis, the report goes on to recommend a series of priorities. The number one priority is the development of standards and guidelines for cancer care.

The CSCC report maintains that given the magnitude of the cancer problem, that no individual organization, jurisdiction or government can effectively control cancer. Therefore, a national strategy is required that will harness the energies of the formalized cancer organizations at the federal, provincial, and territorial levels and also the volunteer sector, for example the Canadian Cancer Society. The purpose of such a strategy is to provide a stable focus and leadership in the face of continuous changes in the health care structures. In other words, without a national strategy the continuous changes in the health care system occurring at the various provincial levels would prove to be an impediment to making progress to the goal of controlling cancer.

The purpose of developing national standards and guidelines is to provide a basis upon which practices can be evaluated and thus improvements made. Currently, guidelines exist in some provinces but they tend to be ad hoc and are not followed across the country. The argument made is that without an ability to evaluate the effectiveness of different treatment modalities, it is difficult to provide the evidence upon which clinicians can determine which are the best treatments to provide to their patients. Given the CSCC

case presented for standardized care guidelines, I question whether individualized care is either feasible or desirable.

Desirability

In Cotter's self-help book, she tells fellow patients that no one member of the health care team can be expected to address all aspects of their care (1999). She goes on to describe the various roles of health care providers, support groups, friends, and complementary therapists. She strongly recommends to patients that they depend on health care workers for those aspects of care that they are uniquely qualified to provide such as treatment, but also suggests that patients should take up the offers of help from friends, and other support persons. Her suggestions indicate that nurses are only one part, albeit an important part, of the support mechanisms that patients might call upon to assist them in their cancer process.

In Chapter Eight I discussed the differing perspectives of patients. Thorne et al. (1999), and Fitch et al. (2002), pointed out the various ways in which women waited for diagnosis, and the variety of needs that they had during this period of time. It would appear that how each individual approaches their disease is somewhat different, but it does not necessarily follow that the way in which nurses approach each patient should also be somewhat different. It seems to me, what these studies are pointing out is that nurses must be open to the notion that each patient will come to the cancer experience with an individual context. It does not mean that patients do not share common features, rather, that it is important to find out what specifically the patient requires to assist them at that time.

Implications

As I argued in Chapter Three, standards of care have their place. However, the standards must be critically examined for what types of practices are endorsed and what types or views of knowledge are included in their development. It is hard to argue with the CSCC position that in order to evaluate care outcomes, practitioners must follow standardized care guidelines, if what you are interested in is the most cost-efficient program of care. If the projected numbers of cancer patients is accurate then it is difficult to imagine how 'individualized' care is possible in a cancer system that is responsible for the care of all cancer patients, and at the same time, it is all individual – in the end as it does come down to each patient seeing each health care practitioner about their personal diagnosis.

One approach that I would put forth would be to acknowledge that in order to care for the increasing volumes of patients that are both currently in the system and anticipated in the future, that perhaps there is only capacity for a certain level of individualization. For example, I do not believe that the change initiative goal of flexible scheduling is achievable. I see that one of the responsibilities of the cancer organizations is to attend to all patients in as timely a manner as possible. I cannot reconcile how this goal can be achieved in the absence of some type of regularized scheduling system. That is not to say that there should not be built in capacity for those individuals due to personal circumstances are unable to 'fit in'. I cited examples in my observations where patients were accommodated if errors in booking occurred or if waiting times were too long. This study also illustrated in Chapter Six that within the existing system there is capacity to work outside of the schedule.

Another approach that might be taken is to be more explicit regarding the role and responsibility of the organization in relation to meeting individual needs. In order to explicate the ability to meet individualized needs, it is imperative to gather that information from patients. One of the difficulties with the change initiative was the apparent lack of patient input into those aspects of the care processes that most needed to be attended to in an individual way. I am not convinced that flexible scheduling would be something that patients would point to as one of their priorities.

Likewise, in terms of nursing care, I am unclear from a patient's perspective how one might approach identifying what aspects of care might best be served on an individual-by-individual basis. At a recent oncology conference, the keynote speaker pointed to the positive difference that nurses make to individual patients (CANO, 2002). At the cancer clinics we receive many cards and letters from patients thanking the nurses for the 'care' they received during their treatments. Clearly the nurses are doing something that is making a difference to these patients. We just aren't clear what that 'something' is.

The needs of patients are currently standardized according to tumour site. Nurses presuppose patient needs based on their experience with patients, and also on the formal educational knowledge that they have received about oncology patients. Much of this knowledge focuses on the disease process, treatment, and management of side effects. The nurses identify in their accounts of practice that individuals have different needs, and at the same time, individualized care was not immediately apparent in the care that they were observed to give. I believe that there is a balance to be struck between viewing patients as diseases, and the ability to meet individual needs. The challenge this presents

is that nurses must recognize and be open to how the current structures and professional guidelines mediate how we have come to view patient needs. It is also important to acknowledge the work that patients have to do to 'individualize' the 'standard' information that they are given.

Currently at the cancer clinics, we are being pressured to 'do things differently'. The belief is that the way patients are currently being seen in the ambulatory clinics cannot be sustained, as the numbers of patients are too great. This reason for making yet another change is similar to the imperative of the original restructuring. The information in this study will be used to open up the discussion with nursing staff and patients. I am optimistic that there is capacity and ability on the part of both nurses and patients to examine some preconceived notions about what is possible before we think about making more changes.

Nursing Themes Expert Knowledge-Expert Practice

Practice as power

In Chapter Eight I examined a new patient appointment in the ambulatory clinic. This examination revealed that N4 drew upon her knowledge of lung cancer disease to facilitate the information that they patient and family needed to know during their visit. N4 demonstrated a caring approach to this family and her demeanour appeared to be one of concern for their well-being. Further, she spent plenty of time with the patient and her family, and in this situation moving the patient through the visit in a manner that was overly concerned with time limits was not observed. However, I contend that the N4's expert knowledge and practices got in the way of 'hearing' the patient and family

concerns, and also set up a power relationship that enrolls patients in the particular ways they are expected to enact the role of a patient.

In Chapter Eight, a patient describes her lack of confidence upon entering the cancer care system. A combination of elements contributes to the intimidating nature of the clinic appointments, not the least of which is the diagnosis of cancer! However, I suggest that the manner in which nurses exercise their expertise in these appointments further contributes to undermining a patient's confidence in their own knowledge. As N4 explained, she has a need to control the appointment to ensure that they don't get off track, as there is lots of information that needs to be conveyed. This effectively controls both the information that the patient is able to relay, and also the information that they will receive.

Power is exercised by the nurses through their practices. These include, the way in which they review the health assessment, the questions they put to the patient, taking the patient's weight, and in this illustration, adjusting the oxygen. At this first appointment, the patient is disciplined in not only the ways of the clinic but also in the ways of being a patient (Foucault, 1977). Representations of the patient are characterized by the nurse in the questions she asks and in the responses she attends to. For example, N4 does not answer the husband's question about what might happen with radiation. Rather, she repeats what the physician previously explained regarding the size of the patient's tumour and the possibility of side effects. N4 does not appear to consider that the husband is asking something that goes beyond the technical aspects of the radiation treatments.

Subjugated knowledge

The nurses in this study lay claim to expert knowledge in the field of oncology. As stated by N5, "I am an expert in a few cancers" (2001). Their accounts of practice draw upon these knowledge claims. In accounts of how they go about their day, they do not acknowledge their local knowledge of 'how things get done' that they use as they enact their practice in the everyday clinic environment. This study illustrates that how they organize their work and enact their practice is very much mediated by their knowledge of the structures of how the clinics run. They seem very aware, without any explanation, what will, and will not be acceptable, and change their practice to accommodate this knowledge. For example, there were no comments when N6 ignored the schedule and stayed with a follow-up patient approximately nine times longer than usual. N6 drew upon her local knowledge when she worked outside of the schedule.

Latimer (1993) suggests that accounts of practice are interpretations of events, which are already interpreted (pre-interpreted) by them. She goes on to say,

Who knows when or how we first noticed something; or how and when we first intended to do something; or why we intended to it; what readings we were actually making at the time, in the setting, for all practical purposes; what knowledge we drew upon, and how we came by that knowledge. The nurses can tell about their experience, and give their view of events, but extrapolating claims from these accounts about best practice is problematic (p. 314).

This study illustrates that there is more to the enactment of practice than those features that nurses' highlight in their accounts. The contradiction between accounts and my observations provides an excellent opportunity to explore the 'other' knowledge that nurses draw upon in their practice. As the observed practices are remarkably similar at both clinics, I argue that if changes are made, then it is these knowledges that must be understood as they have a powerful mediating effect on how things work.

Nurses acknowledge the local knowledge of patients, as illustrated by N4 in her remarks about how patients have individual concerns on their first visit. However, in the observations of practice, the nurses very seldom drew upon the knowledge of patients. Patients' accounts of their symptoms were frequently 'normalized' by the nurses and characterized as the expected features of various treatments. By normalizing the experiences of patients, not only is their knowledge about themselves negated, but patients are also sent a powerful message about the expectations we have of patients to listen to us as we have the expert knowledge.

Surveillance – self-discipline

In responding to the husband's query about radiation, N4 highlights for the patient and family the goal of breathing easier. Although, the patient has not complained about her breathing, N4 sets up the expectation that "breathing easier" is something that is important and something that will be asked about in subsequent visits. In this way, the patient and family become part of the surveillance that occurs in keeping track of how the patient is doing between appointments.

Foucault (1975, 1980) in his analysis of the panopticon described in Chapter Two, maintains that surveillance or in this case the possibility of surveillance sets up a self-disciplining process. The questions of the nurse, and the implicit and explicit expectations of their questions, elicit certain patient behaviours. These behaviours are illustrated by many of the follow-up patients in this study. They have learned what they are meant to do as a cancer patient when they have an appointment in the ambulatory setting. For example, many keep track of their symptoms, such as pain, fatigue, appetite,

weight and so on, as they know they will be asked about these in their appointment. This self-discipline is one example of how patients are enrolled in their own self-surveillance.

Being a patient

Garfinkel (1967) describes how being a 'good juror' is comprised of not only those aspects of jurors that are provided to them in the way of procedures but also accounted for by what they consider might be construed as a good juror. In other words, those who are called to serve, in part base the enactment of a juror, upon the representation of jurors. These representations are informed by the accounts and representations of jurors depicted by others. Likewise, patients are informed in their patient role, not only by the actions and practices of health care professionals, but also by the media, other patients, self-help literature, and a plethora of web based information.

Similar to nurses, patients draw upon their local knowledge of the representations of patients in order to enact their role. One of the strong influences that is suggested by this study, is the language that patients take up in enacting their role. They become well versed in medical terminology. Patients at follow-up visits are well schooled in the language of symptoms, side effects, and expected behaviours. They come prepared to discuss their concerns using the discourses of the medical profession. However, it is not only medical terminology that patients take up. They also take up the language and associated meanings that influence their enactment of being a patient.

Foucault (1972) contends that language as discourse over time shapes and forms the meanings that are constructed regarding social phenomena. In this study, I have pointed to examples where the same language is used by patients, the self-help literature, and the professional literature. For example, cancer as a 'journey' is a commonly

articulated way of describing the way in which patients make sense of their cancer diagnosis. Other common examples in the literature include; being a cancer survivor; living well with cancer; fighting cancer, and so on. (Groenwald, Frogg, Goodman & Yarbrow, 1997). Over time, this language has structured the meaning of being a cancer patient. The current representation of being a patient mediates the practices of patients.

Implications

I suggest that positioning themselves as experts related to their knowledge, distances nurses from their patients. Drawing extensively upon the medical knowledge of the cancer disease, disciplines nurses to think about patients in a particular way, associated with symptoms, side effects, and so on. Patients take up language used to depict patients as they enact their role. Meanings attributed to language create representations of patients that become normalized by both health care professionals and patients alike.

Nurses instruct patients during the clinic visits. The information they give and the information they ask for, powerfully mediates how patients enact their role not only at the clinic but also in their own world. Nurses attend to symptoms and patients take up these features and carry them over into their outside life by monitoring their symptoms. Thus, patients become enrolled in self-surveillance. The disciplining effect of the clinic mediates patient behaviour.

Nurses need to be aware of the distancing nature of their 'expert' knowledge. By presupposing patient needs and controlling the visits, there is very little space for the patient's knowledge. I am not suggesting that nurses set aside the knowledge that they have about cancer diseases and running the clinics as this also offers some structure for

patients to work with. Rather, I am suggesting that they also draw upon the knowledge that patients possess about themselves. It is trying to strike a balance between standardized care and all that implies, and the recognition that it is 'individuals' who present with this disease.

This study illustrates that nurses 'know' much about how things are done in the everyday. They draw upon this local knowledge to work outside of the schedule, to rearrange patient appointments, or in other words to mediate their practices. Yet, these knowledges are buried and only surface when probed. Nurses are seemingly unaware of much of what they 'know' about how their practice is enacted. It is these contextual knowledges that are critical to understand if changes to address the CNAC recommendations are to occur. Therefore, this study provides a useful starting point for exploring more deeply the local knowledge that these nurses make use of to work in the current system.

The observational materials are useful as they resonate with the nurses. In discussions with nurses and nurse leaders, I have already used several of these when exploring issues related to working in the clinics. I suggest that they can be utilized to extend the discussions about clinic practices and the place of patients in those practices.

Nurse Leaders - Hierarchy/Power

Differing perspectives

This study illustrates the differing perspectives of the nurse leaders and the nurses. For example, nurse leaders view 'report' at best as something that the nurses could attend to themselves. None of the nurse leaders are invested in the role of the PON. NL2 suggests that what is important is responsibility and accountability, not the

model of care. As I indicated in Chapter One, nurse leaders are often called upon to account for the practices of nurses. As Foucault (1972) suggests, the interpretations of nursing practice by nurse leaders is problematic as they have the potential to condition and shape other interpretations. In other words, how nurse leaders understand and interpret nursing practice influences how nursing practice comes to be understood by others. In this study leaders' perspectives of how practice is enacted in the everyday is different than the nurses.

None of the four nurse leaders who were interviewed actually participated in the organizational change initiative. They were either in different positions at the time of the change or were not part of the organization. Therefore, their view of the change is informed by the discourses of others. In addition, as I suggested in Chapters One and Two, nurse leaders are also informed and influenced by managerial and leadership discourses. One of the very powerful current views is that espoused by Peter Senge (1990,1994) related to the benefit of organizational consensus. Senge suggests that leaders should create a vision and design a shared purpose around core values. Following this approach, typically one would review the findings in this study and attempt to develop some 'common' understanding between the nurse leaders, and the nurses.

I have maintained that a consensus approach to practice negates the multiple practice contexts and following Mouffe (1996) requires a temporary hegemony that entails some form of exclusion. This study illustrates that points of difference exist not only between the nurse leaders and nurses, between nurses themselves, and between nurses and patients. In this study I have explicated how these differences have come about and the influences that have contributed to these. For example, the nurses at

Meadowview embraced the PON role and those at Brookline viewed it as getting in the way of what had been a good model of care.

Weedon (1999) suggests that the “effect of a post-structuralist theory is to see difference as material, as produced, but as ungrounded in any fixed nature” (p. 24). In other words, the differences depicted in this study are not sedimented, but rather are produced as a material effect of, for example, the change initiative. Differences open up possibilities to expand our knowledge of nursing practice, rather than the prevailing view of nursing practice as a homogeneous activity.

Power/hierarchy

In Chapter One, I discussed the Foucauldian concept of knowledge/power (1972). Foucault maintains that power is always present, is everywhere, and is a structure of actions. Power is more about what happens or the conditions that are present or change as a result of actions. Hindess (1996) suggests that power in this context is “manifested in the instruments, techniques, and procedures that may be brought to bear on the actions of others” (p. 100). This study examined the conditions of possibility that underpin the arrangement of people, nurses, patients, physicians, and nurse leaders, and things such as the schedules and routines in the practice context.

As discussed in Chapter Six, I maintain that ‘report’ is an example of a practice that the nurses have brought to bear on the actions of the nurse leaders. The nurses were observed to wait for the nurse leader to read out their assignments. The action of waiting creates an action on the part of the leader, reading out the assignments. I contend that this is a reversal of what is typically thought to be the hierarchy of power in an organization.

One of the nurse leaders suggested that perhaps the nurses might be reacting to rebukes in the past, if they have taken initiative and that is why they wait. Her explanation suggests that the nurse leader has power 'over' the nurses and somehow this power controls their actions. Following Foucault (1976), power is not something that someone or a position wields over someone else. Rather, individuals both undergo and exercise power. "Individuals are the vehicles of power, not its point of application" (p. 36). 'Report' described in Chapter Six might also be construed as an example of disciplinary power, as the nurse leader is disciplined by the actions of the nurses. She attends report and reads out the assignments.

There are multiples examples in this study of the disciplinary power of the nurses' work in relation to the patients and I have explicated these in this chapter. For example, the health assessment form disciplines patients to respond in a certain manner to certain questions. Likewise, nurses are disciplined by each other to follow the schedule and routines of the clinic. One of the features of the schedule that I point to in Chapter Six is the hierarchal nature of timetables and how these are reflective of power relations within the clinics. However, I also pointed out that nurses have the ability to work outside of the schedule, thus acting in a way that is consistent with Foucault's depiction of individuals as 'vehicles of action'.

Implications

The construction of the role of the nurse is as much about how the nurses enact their practice as that of the nurse leaders who may or may not influence that practice. Points of difference should not be discouraged. Rather, they should be made visible to both nurse leaders, and nurses in order to better understand how each have come to

understand practice in a particular manner. I am not suggesting that the goal of further exploration should be to reach consensus regarding practice. Rather, exploring differences has the potential to deepen the knowledge of nurse leaders and nurses.

By not pushing for consensus, opportunities are opened up to engage in a discussion that does not presuppose one perspective over another. Further, relating the areas of conflict to the knowledge that individuals draw upon to form their perspectives has the potential to lay transparent much about the taken-for-granted assumptions that they draw upon to frame their ideas about practice. For example, the nurses draw upon Benner's notion of novice to expert in explicating their expert practice. This provides the opportunity to hold up Benner's position that narratives represent practice against the findings of this study. The value in this type of discussion is not that conclusions are reached, but that knowledge claims are laid out, in order for nurses to understand what it is they have taken up, and how that guides their actions and the possibilities for knowledge to be generated.

Concluding Comments

My concern in this thesis has been to explicate how an organizational change initiative impacted oncology nursing practices. I was interested in identifying the knowledge that nurses draw upon in their self-identified expert practice, what was included and excluded, absent and present, and mediated through the discourse of oncology practice. Further, as a nurse leader, I was interested in how nurse leaders influence change to practice and the knowledge that one would need to draw upon to understand if changes had actually occurred.

In this study, I dispute that accounts of practice can be taken to be practice.

Accounts are representations of practice. This too, is a representation, albeit one that has been conducted in an in-depth and systematic manner. It would be impossible to claim that this depiction of oncology nursing practice in the ambulatory clinics can be taken to be the totality of that practice. However, although my study is confined to two oncology clinics, I suggest that the organizational practices depicted in this study will resonate with readers. The approach that this organization undertook in their organizational change is very similar to those that continue to be undertaken in other health care organizations.

This thesis has laid out how practice is enacted in these two clinics and the contextual features that influence that enactment. Nursing leadership is a powerful influence. Nurse leaders are not only called upon to account for practice, but, in turn, also call upon the nursing staff to account for their practice. I encourage nurse leaders to challenge my interpretation and representation of oncology nurse leader practice. I further encourage nurse leaders to challenge their assumptions about how, and why, they ask for accounts, and the place that such accounts play in making changes to practice.

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Appendices

Appendix 1: Certificate of Approval



University of Victoria
Human Research Ethics Committee

CERTIFICATE OF APPROVAL

<u>Principal Investigator</u>	<u>Department/School</u>	<u>Supervisor</u>
Roberta Lynn Stevenson Graduate Student	Nursing	Dr. Mary Ellen Purkis


Co-investigator(s):
N/A

Title: In the Name of Cancer Nursing: An Exploration of Oncology Nursing Practice

<u>Project No.</u>	<u>Start Date</u>	<u>End Date</u>	<u>Approval Date</u>
343-00	01 Dec 00	30 Nov 01	30 Nov 00

Certification

This is to certify that the University of Victoria Ethics Review Committee on Research and Other Activities Involving Human Subjects has examined the research proposal and concludes that, in all respects, the proposed research meets appropriate standards of ethics as outlined by the University of Victoria Research Regulations Involving Human Subjects.


J. Howard Brunt,
Associate Vice-President, Research

This Certificate of Approval is valid for the above term provided there is no change in the procedures. Extensions/minor amendments may be granted upon receipt of "Request for Continuing Review or Amendment of an Approved Project" form.

Office of Vice President Research
Room 424, Business & Economics Building
P.O. Box 1785,
Victoria, BC V8W 2Y2

Tel: (250)472-4362
Fax: (250)721-8960
Email: hllaman@uvic.ca

Appendix 2: Staff Information Session Hand-out

September, 2000

Dear Potential Participants:

My name is Lynn Stevenson and I am the nursing Professional Practice Leader at a cancer agency and doctoral student at the University of Victoria. As part of the requirements for my PhD in nursing I am conducting a research study at the Brookline and Meadowview Clinics. The purpose of my study is to understand the context of nurses' practice, by observing that practice and by conducting individual interviews with nursing staff, managers and professional practice leaders. Typically, changes in nursing practice occur based on some type of 'fashionable' organizational or leadership idea, for instance quality improvement ideas. I am interested in developing a deeper understanding of how nurses practice, so that strategies to make practice changes will be based on knowledge generated from practice rather than from assumptions made about that practice. Specifically, I am interested in gaining an understanding of how oncology nurses **describe** their work and what indeed that work **looks like** when observed. I will be observing your practice and talking with you about your practice for 2-3 hour blocks in the clinic over the next 3 months.

You are invited to participate in this study. By agreeing to participate, you are indicating your permission to have me observe you in your everyday work in the clinic. I will be in the clinic observing nursing practice over a 3 month period of time and you will be involved in several of these observation sessions. You are also agreeing to take part in one and perhaps two individual interviews of approximately 1-hour duration.

Participation is voluntary and there are no risks associated with participating. All interviews (with permission) will be tape recorded and transcribed for analysis. Names and identifying information will not be transcribed and anonymity will be ensured by the used of fictitious initials. Only my graduate supervisor Dr. Mary Ellen Purkis and I will have access to the audiotape recordings and transcribed information. The interview tapes and field notes will be kept in a locked filing cabinet in my home office until the study is completed and then will be destroyed.

If you are interested in volunteering please contact **Ms. Mary Jones (250-370-836)** who will not be participating in the study and will pass on your name to me and I will arrange to meet with you to sign the participant consent, (250)370-. Your willingness to participate in this study is greatly appreciated, however, there is no penalty of any kind if you choose not to participate. You may choose to withdraw from the study at anytime and can do so by notifying me directly or by notifying Ms. Jones. If you withdraw from the study, your data will be destroyed upon request.

I will be sharing the results of my study with the nursing staff at the participating centers and will provide a copy of my dissertation to the agency library.

If you have any questions about this study, please contact my supervisor Dr. Mary Ellen Purkis (250) 721-6284 at the University of Victoria, or Lynn Stevenson 877-6098 local 2623.

Appendix 3: Consent- Nurses (individual interview and observations)

You are being invited to participate in a study entitled: **In the name of cancer nursing: An exploration of oncology nursing practice**, that is being conducted by me, LYNN STEVENSON. I am the nursing Professional Practice Leader at the Cancer Agency and doctoral student in the School of Nursing at the University of Victoria and you may contact me if you have further questions by calling (250) 658-8792. As a graduate student this research is part of the requirements for a degree of PhD Nursing and it is being conducted under the supervision of Dr. Mary Ellen Purkis. You may contact her at (250) 721-6284.

The purpose of the research is to obtain a deep and rich description of how oncology nurses conduct their practice. Research of this type is important because typically changes to nursing practice are based on 'fashionable' organizational or leadership ideas rather than on a comprehensive understanding of how nursing practice actually occurs and what types of phenomena influence that practice. The premise is that there are many 'perspectives' regarding nursing practice and an attempt to illuminate these perspectives will reveal new understandings about nurses' practice. The premise is that this information could be utilized in determining how nursing practice changes could be undertaken.

If you agree to voluntarily participate in this research, your participation consists of being observed during your regular work hours doing your regular work and during interactions with patients over a three-four month period beginning December, 15, 2000. In addition, you are also agreeing to take part in one and perhaps two interviews that will be audiotaped. There are no known risks to you by participating in this research. A potential benefit of your participation in this research is that they study may produce information of use to patients, nurses or administrators in the future and benefit oncology nursing practice.

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do wish to withdraw from the study you may do so by notifying me directly or Ms. Mary Jones at (250) 370-8736 Your data will, if you agree, be used in the analysis. Your data will be destroyed upon your request.

To make sure that you continue to consent to participate in this research, I will remind you about the terms of participation (e.g., voluntary, ability to withdraw etc.) at the beginning of each observation.

Your confidentiality will be protected by storing the observation data, my field notes, audiotapes, and transcripts in a locked filing cabinet in my home office. Only my supervisor Dr. Purkis and I will have access to the data. Audiotapes will be erased and field notes, observational notes and transcripts will be destroyed by me upon study completion.

To preserve your anonymity, your name will not be recorded on the transcribed data; a code or pseudonym will be assigned and used in place of your name. The key to the coded names will be kept separately from the observation data. Signed consent letters will also be stored separately from any data.

The results of this study will be shared with others in the following ways: A copy of the study results will be made available to the cancer clinics(s) involved in the study and a copy will be placed in the clinic libraries for use by patients and staff. The results will be documented in my dissertation, published in peer-reviewed journal, and will also be presented at professional and/or scholarly conferences.

In addition to being able to contact the researcher and my supervisor Dr. Mary Ellen Purkis at the above phone numbers, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice President Research at the University of Victoria (250-721-7968).

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researchers.

Participant Signature

Date

**A COPY OF THIS CONSENT WILL BE LEFT WITH YOU, AND A COPY WILL
BE TAKEN BY THE RESEARCHER**

Appendix 4: Consent – Nurse Leader – Individual Interview

You are being invited to participate in a study entitled: **In the name of oncology nursing: An exploration of oncology nursing practice** that is being conducted by me, LYNN STEVENSON. I am the nursing Professional Practice Leader at the Cancer Agency and a doctoral student in the School of Nursing at the University of Victoria and you may contact me if you have further questions by calling (250) 658-8792. As a graduate student this research is part of the requirements for a degree of PhD Nursing and it is being conducted under the supervision of Dr. Mary Ellen Purkis. You may contact her at (250) 721-6284.

The purpose of the research is to obtain a deep and rich description of how oncology nurses conduct their practice. Research of this type is important because typically changes to nursing practice are based on 'fashionable' organizational or leadership ideas rather than on a comprehensive understanding of how nursing practice actually occurs and what types of phenomena influence that practice. The premise is that there are many 'perspectives' regarding nursing practice and an attempt to illuminate these perspectives will reveal new understandings about nurse's practice. The premise is that this information could be utilized in determining how nursing practice changes could be undertaken.

If you agree to voluntarily participate in this research, your participation consists of agreeing to take part in one and perhaps two interviews that will be audiotaped. There are no known risks to you by participating in this research. A potential benefit of your participation in this research is that they study may produce information of use to patients, nurses or administrators in the future and will benefit oncology nursing practice.

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study you may do so by contacting me or Ms. Mary Jones at (250) 370-8736. Your data will, if you agree, be used in the analysis. Your data will be destroyed upon your request.

To make sure that you continue to consent to participate in this research, I will remind you about the terms of participation (e.g., voluntary, ability to withdraw etc.) at the beginning of each observation.

Your confidentiality will be protected by storing the audiotapes and transcripts and my field notes in a locked filing cabinet in my home office. Only my supervisor Dr. Purkis and I will have access to the data. Audiotapes will be erased and transcripts shredded at the completion of the study.

To preserve your anonymity, your name will not be recorded on the transcribed data; a code or pseudonym will be assigned and used in place of your name. The key to the

coded names will be kept separately from the observation data. Signed consent letters will also be stored separately from any data.

The results of this study will be shared with others in the following ways: A copy of the study results will be made available to the cancer clinics(s) involved in the study and a copy will be placed in the clinic libraries for use by patients and staff. The results will be documented in my dissertation, published in peer-reviewed journal, and will also be presented at professional and/or scholarly conferences.

In addition to being able to contact the researcher and my supervisor Dr. Mary Ellen Purkis at the above phone numbers, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice President Research at the University of Victoria (250-721-7968).

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researchers.

Participant Signature

Date

**A COPY OF THIS CONSENT WILL BE LEFT WITH YOU, AND A COPY WILL
BE TAKEN BY THE RESEARCHER**

Appendix 5: Interview Schedule

The following unstructured, open-ended questions are designed to assist nurses, managers and professional practice leaders to provide accounts of their experience of how it is that oncology nurses' practice in the cancer clinics. The questions are general and non-directive and are structured by both the researcher and informant (Hammersley & Atkinson, 1983). These questions will be used as a guide and each of the questions will be probed by the researcher to elicit accounts of specific aspects of oncology nursing practice.

A. Lead questions for nurses:

- Describe a usual day for you – what types of things make it 'usual'?
- How do you plan your day? (priorities, schedules)
- How do things 'get done' around here?
- Nurses describe themselves as primary nurses – what does that mean to you? Are there aspects of your work here where you feel particularly able to act as a primary nurse to the patients you are assigned to?
- Do you sometimes feel that there might be other ways to do ____?
- How do changes in nursing practice occur?
- How do changes to your practice occur?
- When things work 'well' during your day, what do you think contributes to that?
- When things don't work 'well', during your day, what do you think contributes to that?

B. Lead questions for managers/professional practice leaders

- Describe a usual day for oncology nurses
- How do nurses 'know' how to plan their day?
- How do things 'get done' around here?
- What role do you have on how things 'get done' or how nurses plan their day?
- Nurses describe themselves as oncology primary nurses, what does that mean to you?
- Do you sometimes feel that there might be other ways to do ____?
- How do changes to nursing practice occur?
- When things work 'well' at the clinic, what do you think contributes to that?
- When things don't work 'well' at the clinic, what do you think contributes to that?

Appendix 6: Permission for researcher to approach patients - Script

Lynn Stevenson who is the nursing Professional Practice Leader at the Cancer Clinic is also a doctoral student at the University of Victoria. As a doctoral student, Lynn is conducting research into oncology nursing practice. One piece of that research is to observe nurse-patient interactions. Is it okay for Lynn to speak to you about her research to see if you are willing to have your interactions with your nurse observed?

Name _____

Yes _____ No _____

Thank you for your consideration.

Appendix 7: Consent-Patients

You are being invited to participate in a study entitled: **In the name of cancer nursing: An exploration of oncology nursing practice**, that is being conducted by me, LYNN

STEVENSON. I am the nursing Professional Practice Leader at the Cancer Agency and a doctoral student in the School of Nursing at the University of Victoria and you may contact me if you have further questions by calling (250) 658-8792. As a graduate student this research is part of the requirements for a degree of PhD Nursing and it is being conducted under the supervision of Dr. Mary Ellen Purkis. You may contact her at (250) 721-6284.

The purpose of the research is to understand the context of nurses' practice by observing their practice and by conducting individual interviews with nursing staff, managers and professional practice leaders. Research of this type is important because typically changes to nursing practice are based on 'fashionable' organizational or leadership ideas rather than on a comprehensive understanding of how nursing practice actually occurs and what types of phenomena influence that practice. The premise is that there are many 'perspectives' regarding nursing practice and an attempt to illuminate these perspectives will reveal new understandings about nurses' practice.

If you agree to voluntarily participate in this research, your participation consists of being observed during your interaction with your oncology nurse(s). There are no known risks to you by participating in this research. A potential benefit of your participation in this research is that the study may produce information of use to patients, nurses or administrators in the future and will benefit oncology nursing practice.

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you wish to withdraw from the study, you may do so by notifying me directly or **Jane Doe at 250-727-4364**. Rita is a health care worker not associated with the cancer agency. If you do withdraw from the study your data will, if you agree, be used in the analysis. Your data will be destroyed upon your request.

To make sure that you continue to consent to participate in this research, I will remind you about the terms of participation (e.g., voluntary, ability to withdraw etc.) at the beginning of each observation. If you have any questions or concerns about the study you may notify me or my supervisor Dr. Mary Ellen Purkis or contact Jane Doe.

Your confidentiality will be protected by storing the observation data and my field notes in a locked filing cabinet in my home office. Only my supervisor Dr. Purkis and I will have access to the data. Field notes and observational data will be destroyed upon study completion.

To preserve your anonymity, your name will not be recorded on the transcribed data; a code or pseudonym will be assigned and used in place of your name. The key to the

coded names will be kept separately from the observation data. Signed consent letters will also be stored separately from any data.

The results of this study will be shared with others in the following ways: A copy of the study results will be made available to the cancer center(s) involved in the study and a copy will be placed in the center libraries for use by patients and staff. The results will be documented in my dissertation, published in peer-reviewed journals, and will also be presented at professional and/or scholarly conferences.

In addition to being able to contact the researcher and my supervisor Dr. Mary Ellen Purkis at the above phone numbers, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice President Research at the University of Victoria (250) 721-7968).

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researchers.

Participant Signature

Date

**A COPY OF THIS CONSENT WILL BE LEFT WITH YOU, AND A COPY WILL
BE TAKEN BY THE RESEARCHER**