How Nurses Practise Health Care Reform: An Institutional Ethnography

by

Janet Mary Rankin
BScN, University of British Columbia, 1986

A Dissertation Submitted in Partial Fulfillment of Requirements for the Degree of

DOCTOR OF PHILOSOPHY

in the Faculty of Human and Social Development

Supervisor: Dr. Marie Campbell

Abstract

The Canadian public service sector, particularly health care, has been undergoing restructuring following trends set in what many are calling "the new public management". This institutional ethnography addresses questions surrounding nurses' participation in Canadian health care reform, tracking the lived actualities of nursing work, organized within widespread practices of hospital management. It critically examines the use of a proliferating set of managerial technologies (standardized programs for bed utilization, care-pathways, patient-centred-care and integrated programs) that are expected to improve efficiency and provide more accountability. Using participant observations, textual analysis, and interviews, it explicates the contemporary social organization of nurses' knowledge and action. Central to this analysis is the understanding that managerial undertakings in restructured hospitals are massively textual and information based. The analysis turns on careful empirical exploration of who knows what, and how different forms of knowledge are generated and employed. The texts being introduced into nurses' work appear merely to improve efficiency, yet these efficiency methods are not neutral. The argument made is that nursing work and patient care are deleteriously affected through nurses' interaction with textual tools designed to serve the business-orientation that is central to the restructured approach. Nurses are coached and monitored in their restructured activities by a corps of front-line-nurse-leaders, previously known as head-nurses, whose work has been formally restructured to subordinate clinical expertise to organizational demands. A nursing discourse that blends managerial and nursing ideas and goals supports their rationalization of workplace strategies that organize them to address their patients as objects of an organizational order – worked up into texts – for text-based, managerially-relevant action.

An important, if troubling, finding is that the text-based hyper reality, upon which restructuring is based, builds apparently factual knowledge about what is going on in hospitals that may be at odds with on-the-ground actualities. The study offers insights into how the new expectations and regulatory practices to which nurses are being held produce serious contradictions for nurses, patients and the nursing profession.

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Acknowledgments

It is a privilege to acknowledge the people who have supported me to begin, sustain, and complete this project.

Dr. Marie Campbell ~ My mentor extraordinaire, whose balanced, honest feedback on every aspect of this work helped to clear my vision, whose knowledge and questions consistently challenged me to stretch further, and whose detailed assistance has been indispensable. This thesis registers the overwhelming generosity of time she devoted to reading and commenting on drafts too numerous to count.

Mary Lou Landry ~ My life partner whose love and support fed me throughout the long (long) years of study, whose companionship greatly lightens my heart. Mary Lou's exacting approach to nursing and her wise insight into her everyday/everynight nursing work has consistently kept me grounded in what is real.

Brian and Ann Rankin ~ My parents, whose faith in my ability has always inspired me.

My sisters and many friends ~ whose good company helped me to maintain balance and perspective and who have been unfailingly understanding when I have "postponed" time together in order to spend untold hours at my computer. Thank you all for your patience and support.

My colleagues and students at Malaspina University-College ~ whose support I have felt in very tangible ways, and whose interest in my work provided a forum for me to discuss and puzzle over my findings.

The nurses in direct practice (especially the bold nurses of NUC) ~ whose commitment to nursing, and whose own good knowledge about what is actually happening sustains my hope for the future.

How Nurses Practise Health Care Reform: An Institutional Ethnography

Introduction

Is the Canadian health care system in trouble at the beginning of the new millennium? Many Canadians think so. The question is being broached from many different angles. Issues of health care figure prominently in both the popular press and in scholarly research. Everyone from local citizens and health care recipients to health care professionals, administrators, policymakers and politicians have positions and views. Many of these interests came together to make health care the centrepiece of debate in the 2000 federal election and the subsequent commissioned report *Building on Values: The Future of Health Care in Canada* (Romanow, 2002). While the Romanow report made a clear case to limit efforts to privatize health services, to a large extent the findings and recommendations supported the health care direction taken throughout the 1990's. These efforts focused on better *management* of services through reform and restructuring. Better management is heralded by many as the answer to mounting problems of "run away" costs, accessibility and sustainability (Romanow, 2002). What seems clear from all this attention focused on health care over the last decade is that Canadians are looking for reassurance that the publicly funded system of health care is providing Canadians with an acceptable and sustainable standard of health services.

As a nurse, an instructor of nursing students and an active member of the nursing profession, I have my own interests in health care. I am committed to ensuring that nurses provide competent and compassionate nursing care. What I am hearing from my

nursing colleagues and what I observe in my work in hospitals, is that competent and compassionate nursing is becoming an elusive practice. Many of the nurses I encounter in my work are troubled by the shape their nursing practice has taken. The research that I have undertaken as a doctoral candidate offers me the opportunity to pose my own questions as to how nurses and nursing are implicated in the drama of health care reform that is being played out in Canada.

Nurses and nursing have not been the apparent focus of policy and program alterations promoted and implemented to restructure the delivery of health care. The restructuring efforts have been focused on organizational restructuring with concurrent changes in how health care funding is allocated and how certain services are to be delivered. The goal is to provide health care more efficiently and effectively. A hospital executive director I interviewed enthusiastically described his hospital's move to an organizational structure known as "Integrated Programs". As he described the changes he commented: "this move is really not going to impact nursing". In reformed hospitals, nurses continue to go to work, and are expected to provide nursing care as usual. *Or do they* – provide care "as usual"? It is around this issue, of *how* nurses are involved in reformed institutions, programs, and methods of administration that my own inquiry arises.

The attention to health care and health care costs has produced a robust discourse in health, hospital, and nursing administration. My study of nurses' work is located in relation to this discourse, which provides detailed instructions for restructuring hospital programs. The aim of hospital reform is to: "initiate the best practices to reduce costs

without compromising the level of patient care" (Cybulski et al. 1997, p. 162). The challenge for hospital administrators is to establish ways to modify professional practices, to reframe and reconstitute them so as to reduce costs while at the same time being accountable for an uncompromised quality of patient care. My interest is in what this means to nurses, and to how they[1] conduct their work. Here I use a research process to turn health reform "inside out, like a shirt, so we can inspect the seams of construction" (Mueller, 1995, p. 106). I make visible the social relations organizing a troubling transformation of nurses' work. I make an analysis explicating the field of professional/managerial relations, which alters not only nurses' practices, but nurses' consciousness too. I argue that reforming health care relies on *reconstituting knowledge*, in order that health care decisions can be made in a more business-like way. The reconstituted knowledge about health care, hospital and nursing practices is used to make hospitals more cost effective. Corporate efficiency is being inserted as a ruling relation into every single decision a nurse might make in her everyday/everynight practice. Contradictions and conflicts emerge as nurses collaborate in and coordinate the new efficiency mandate, which, I argue, frequently works against the interests of nurses and their patients. Paradoxically, nurses contribute, as participants, to the very workplace troubles they rail against.

Institutional Ethnography – A particular way of looking

Institutional ethnography (IE) is an "alternative sociology" developed by Canadian sociologist Dorothy Smith (1987, 1990a, 1990b, 1999, 2001). Smith's research approach rests in the social organization of knowledge. Hers is a research methodology, which asks – how do we know what we know, how does the social get put together through our

"knowledgeable" practices? A researcher using institutional ethnography works to understand people's activities within their day-to-day troubles, and to discover how these troubles are put together. The focus of an institutional ethnographic analysis is to discover *how* things happen the way that they do. An institutional ethnographer asks: How is our world put together through the *work activities* and *actions* of the actors? Institutional ethnography is a materialist, empirical research approach which relies on the ontological presupposition that an actual world exists that can be interrogated. Smith contends that as embodied, locally situated actors in this world we are organized to act and to produce in certain ways that can be observed and analyzed – I bring that interrogation of the world to nurses and nursing. Smith's method provides an alternative to the abstracted world of quantitative methods and even the theorized interpretations of qualitative approaches.

My institutional ethnographic approach to the research required that although I would begin by noticing my own and other nurses' theories and explanations about what was going on, I would move away from those theories and explanations, to study what was actually *happening*. I tracked what is happening in nursing using participant observations and collecting ethnographic data. I began to see that nurses, who are presumed to function within a model of discretionary professional decision making, are organized to make their nursing decisions in alignment with the newly developing and restructured goals of reformed organizations. What I have discovered provides a departure from other versions and explanations about what is happening to nursing in restructured hospitals

which, for the most part, measure nurses' ability to meet practice standards, or rely on data about "patient outcomes" in order to evaluate the impact of reform.

My analysis relies on Smith's methodological "discovery" related to the materiality of texts and the activation of texts by people. My work takes as its intellectual/ontological basis Smith's (2001) accounts of textually-mediated organizational action. This dissertation will show how nurses' work is infused with, and held in place by, a plethora of textual practices. Textual information produced by nurses is used within the hospital/health care organization (often in sites distant from the local site of nursing practice) to manage and coordinate local practices. Institutional ethnography uses the "materiality" of texts to provide the ground for an empirical analysis into what is happening within contemporary nursing. My analytical focus on knowledge and knowing suggests that the restructured knowledge about hospitals and patients, while providing the basis for reforming hospital practices, is not a unitary view. This is the basis for the critique my dissertation offers.

The study

My inquiry relied primarily on ethnographic methods of participant observation. My observations were conducted through both formal research access and informally through my personal and professional dealings within hospitals. A principal opportunity for preliminary fieldwork arose during my own work, as a nursing instructor, supervising students during their practice experiences in hospitals. A second, important site of data emerged from my network of family and friends who work in, or who have experienced as a patient, a variety of nursing settings. During this preliminary stage I formulated my

research problematic and developed "hunches" about what was happening by recording and reflecting on my own activities, questions and involvements in hospitals. Later, as the analysis developed, I established formal research connections with some of the people who were active in the settings where I was "noticing" things. I obtained formal consent (Appendix A) to interview them. Observations, informal talk, formal interviews, along with the many texts found in the hospital setting provided the data I used to explore nurses' organizational relations.

My ethnography treated any person who had insider or practical knowledge about contemporary Canadian hospitals (friends and family members who have been hospitalized, nurses, doctors, administrators, other hospital workers etc.) as potential informants. Informants were recruited by word of mouth. One person in the hospital would refer me on to another person in the hospital who "knew about" or who "knew more about" the work processes I was exploring. Often this referral was related to the use of the documents I was interested in learning about, the reports and forms that nurses, clerks and administrators use in the course of their work. Informants emerged as the research progressed.

Some of the data presented serendipitously as my own life and work unfolded. One source of data was the ten-day hospitalization of my aunt who had accidentally fallen off a ladder and sustained a serious head injury. Despite the fact I did not have a formal research relationship in the hospital where my aunt was hospitalized I talked to several people at that hospital who were able to answer my questions about how things related to

her care "worked". I conversed with the nurses who were caring for my aunt during her hospitalization and also contacted people at the hospital afterwards when I began analyzing a package of survey materials that was mailed to my aunt three months after her discharge home. In my follow-up conversations I spoke to a nurse clinician, to a nursing unit manager and to the coordinator of hospital evaluation.

Recruiting participants in this manner raised issues of confidentiality and anonymity. The chronology of events, identifying features of documents and so forth required that I make full use of strategies such as changing inconsequential features of the data and using pseudonyms to protect the identity of the agencies and people. The Tri-Council (1998) policy statement about "naturalistic observation" guided my ethical conduct. I ensured that the research observations I made, both during formally arranged participant observations and during my own work and personal experiences in hospitals did not allow for identification of subjects and it was not staged. As such, it was regarded as "minimal risk" for ethical conduct. Despite the fact that "sample size" is not an issue for institutional ethnographers, I explicitly gathered data from five BC hospitals to protect the anonymity and confidentiality of the informants. Data collection at agencies where I did not have formal access was covered in the Tri-Council policy statement (1998) that states, "Consent is not required from organizations such as corporations or governments for research about their institutions" (p. 2.2). All informants I interviewed were informed that the research I was conducting was a "critical study" of health care reforms, with a particular interest in how hospital restructuring played out in nurses' work. So informed,

they participated freely in the research. My proposed study methods were reviewed and approved by the human subjects review committee at the University of Victoria.

My method of talking to people was informed by G. Smith (1995) who coined the term "politico-administrative regime" a notion he adopted "as a mechanism for facilitating an investigation and description of how ruling is organized and managed by political and administrative forms of regulation and control" (p. 25). George Smith was challenged to investigate these forms of regulation and control in what, for him (working with the AIDS regime), was an "activist confrontation" with the policy-interested bureaucrats and professionals. Thinking about contemporary hospital practices as part of a politico-administrative regime directed how I proceeded with my data collection. I took a standpoint different from the ruling politico-administrative regime. As a family member, I took the standpoint of a patient. As a nursing instructor, who needs to keep up to date with how hospitals run and to learn what is being expected of nurses, I attempted to take the standpoint of practicing nurses. As a nursing colleague, I took the standpoint of nurses committed to proficient practice.

The processes and procedures established to ensure that research carried out in institutions (such as hospitals) is ethical could not easily accommodate research designed to look closely at the institutional processes themselves. Although I adhered closely to my university's requirements for ethical research, I found some of these requirements awkward, not really addressing my research interests and practices. Like George Smith, I "never collected data in general using a standard protocol with the intention of making

sense of it later" (1995, p. 26). I learned however I could about the work that was being accomplished, the way that nurses addressed their tasks, how managers thought about their responsibilities, how the work of clerks got done, and how family members worked to articulate patient care between hospital and home. As I collected data I noted competent people conducting their work well. I did not ask for participants' perceptions, opinions or political views about their hospital work. Rather, I observed them and questioned them about how they got through their days, going competently from one duty to the next. Where I quote or refer to nurses' own criticism (for example, the work of a group of nurse activists with whom I was involved), the criticisms, and indeed the people involved, have already been made public. Focused on the politico-administrative regime, I was not involved in the study of "human subjects" in the way that human subjects are generally thought about. Even when engaging in conversations about someone's work, my ethnographic interest always focused on the informant's contribution to the working of the regime, not in the individual or their "perspective". Institutional ethnography relies on understanding people's actions undertaken as part of the social organization of the research setting. As such it creates difficulties for standard methods of consent and ethical review.

Following a lengthy series of meetings with hospital administrators, I was able to establish a formal research relationship with one British Columbian hospital. At this hospital I conducted formal participant observations. I also conducted several formal interviews with nurses, head nurses, bed utilization clerks, medical records clerks, patient services directors, and an executive director. At this hospital I gathered many of the

organizational texts I analyzed – formal agendas, minutes, memos, policy and procedure manuals, record keeping forms, journal articles, surveys and so forth. Beyond my formal hospital access I also accessed my personal experiences and my network of administrators and nurses working at five other BC hospitals. Some of these people agreed to be formally interviewed (tape-recorded transcripts) about their work. Others responded to my queries and questions about the operation of the health care system via e-mail. These people also provided texts and information that allowed me to investigate how their work intersected with boards, ministries, professional regulatory bodies etc. Following the "leads" from my informants I secured one interview with an administrative bureaucrat at the ministry of health and interviewed one member of the board of a regional health authority. The conversations with informants were not standardized. Rather, the point of each interaction was to discover the work practices of their everyday life, to learn about what each informant actually did, the effort they expended to construct the organization of contemporary hospital care.

As my work progressed I began to understand how knowledge itself is contested within institutions of contemporary health care. My analytical work began to illuminate what seemed to be important knowledge disjunctures. That the analysis I go on to develop becomes a critique of the very taken-for-granted, proficient, capable activities that I observed and recorded is likely to be disconcerting to all participants. Throughout the dissertation I stress that my critique is not a critique of individuals, or particular agencies, but rather, the data is used to explicate the politico-administrative regime and to provide a scientific ground for political action.

The Chapters: An overview

Chapter one

Troubles in the everyday/everynight world of nurses: The problematic of the inquiry.

In institutional ethnography, a "problematic" offers a way to write and talk about a researchable puzzle. It is a technical term. It operates to position and stabilize how one is to think about the research, grounded in the actual activities of everyday people. The problematic one chooses to explore helps to establish the research "standpoint", locating the researcher on a particular side of a "line of fault" in knowing (Smith 1987). The problematic is also used as a methodological tool to find entry points or clues for exploring the social organization of what has been rendered puzzling. Starting with the problematic, "the process of inquiry is rather like grabbing a ball of string, finding the thread, and then pulling it out" (McCoy and DeVault, 2000, p. 751).

To identify my problematic, I detail three instances of puzzling things happening at various sites of nursing practice. I use them to illuminate subtle contradictions that, until questioned, may not appear contentious. In later chapters I write about how I followed clues from these accounts. I explicate their coherence through analysis of data that I collected about the activities of people who, although perhaps not directly involved in the "happening", are nonetheless implicated in the way it unfolds. The accounts I describe provide the ground from which I investigate, empirically, "*how* it is happening".

The methods of data collection and analysis I unravel from the problematic, into the larger organization, produces a general argument about the way that health care reform and hospital restructuring is "working"; how administrative and managerial efforts are being played out in real lives. Not only in the lives of the people whose activities I chronicle in this chapter, but also in the lives of other people, similarly located – on *this* side of the line of fault – within the politico-administrative regime of Canadian hospitals.

Chapter Two

Canadian health care reform and hospital restructuring: Setting the context

This chapter locates my inquiry within the discourse of Canadian health reform and hospital restructuring. Health reforms have been initiated during a political era in which public concern has been focused on issues of national spending. Health care reform is occurring within considerable changes to global capitalism that dominate the Canadian economy. In the field of health administration, these public/policy concerns have led to efforts to find efficient and cost-effective ways to organize hospital operations.

The solutions that have been sought to change organizational designs, improve productivity and balance budgets have evolved from the business paradigm of "for-profit" industries. I situate my inquiry in relation to what is being said within the dominant hospital administrative discourse. I draw on the massive management literature that has been built up around the complex of administrative technologies currently used in Canadian health care settings. I review them as a set of instructions and provide

readers with a background understanding about the new models of organizational design as they are applied to hospitals. The voices that are being raised in critique of the dominant business-oriented approaches to health care administration are also discussed in this chapter, as I locate my inquiry within some of the debate about health and hospital services during the past decade.

Chapter Three

Developing the theoretical and methodological frame. Institutional ethnography.

In this chapter I elaborate on institutional ethnography as a distinctive approach to research based on Dorothy Smith's analysis of the social organization of knowledge. The methodological approach is a critical component of the conceptual framework I used to explore contemporary nursing practices. I review how I use some of institutional ethnography's terminology, the theoretical language that expresses and directs the differences between institutional ethnography and other theoretical traditions and research methodologies. I describe how the theoretical "tools" provided by Smith avoid the "conceptual leap", into abstract explanations, that mark the radical turn of Smith's approach. I outline how I use the theoretical foundations of institutional ethnography, as a strategy, to explore and explicate the experiences of nurses working in contemporary hospitals.

Chapter Four

Constituting health care knowledge in managerial form.

Moving into the hospital setting, chapter four follows activities rendered puzzling in my observations of nurses and the administrative methods being used to make hospitals run

more efficiently. The analysis focuses on the central place of knowledge in the new, more efficient, organization. Hospital restructuring relies on a body of information that is used to manage both clinical and administrative hospital operations.

In this chapter I describe three administrative systems used to inform managerial decision-making and analyze how nurses are implicated in both the generation of, and the response to, information that is generated for efficiencies. Grounded in actual activities at the front-line[2] of nurses' work, I explicate a system of organizing patients into and out of hospital beds known as the Admission/Discharge/Transfer system (ADT). I also explore Alternate Level of Care (ALC) a system of categorizing patients to determine whether or not hospital beds are being used appropriately. Finally I look at a system that surveys "Patient Satisfaction". The administrative technologies I describe represent a range of technical approaches to generating information that has management capacity and use. I show how the work-up of patients into new forms of knowledge, whereby they become "information", inserts a particular interest into nurses' work and how managerial concerns are entwined and concerted with nurses' clinical and professional concerns.

Chapter Five

Organizing practices of reform: Enforcing nurses' participation.

Nurses in their everyday/everynight practice are involved when large aggregates of computerized data are used to identify apparent inefficiencies in the new business-oriented approaches to running hospitals. The "improvements" generated within health care reform are achieved through restructuring and standardizing how patient care is

delivered. Within these initiatives, nurses' knowledge about how to conduct a competent nursing practice is also restructured.

In chapter five I explicate *how* nurses and nursing work are involved in the new efficiencies. I expose systems of managerial enforcement that organize nurses' discretionary practices with their patients. Standardized "care pathways" aimed at producing "best practices" (generated through evidenced-based health services research) are one piece of the puzzle explored in this chapter. I use documented minutes from meetings, and interviews with nurses and nurse administrators to reveal how text-based strategies that standardize and ration nursing actions are implemented and enforced. I display how these efficiency-oriented practices displace nurses' autonomous knowledge and reliance on their own judgement when working with patients.

Chapter Six

Front-line-nurse-leaders at the "line of fault": Reorienting clinical leadership.

This chapter analyzes the evolution of the work of head nurses as it has been reformed through changes in hospital management structures and how head nurses' work is implicated in new efficiencies. I explicate how the work of head nurses is being changed from its clinical orientation to management of nursing. As with staff nurses, the knowledge head nurses rely upon to produce a proficient practice, is being reformed. I display how the activities of nurses in front-line-leadership positions (who are now referred to by a variety of different titles) are institutionally organized to structure nurses' rationing practices as a ruling relation directing nurses' discretionary work. I describe

how competitive, market-like relations are established that support a new framework through which the competence of nursing leadership is judged. I argue that nurses have lost an important clinical resource as a result of this restructuring.

Chapter Seven

Colonizing nurses' language: An evolving professional discourse of efficiency

In this chapter I explicate the regulatory capacities of a professional nursing discourse and identify how it, too, acts as an enforcement strategy. A level of discomfort – for nurses – arises when their sense of altruism collides with the newly required practices of efficiency. Adapting to the demands of bed shortages and rapid discharges can produce activities antithetical to an "ideal" nursing practice.[3] Focusing on nurses' use of language I display how words, and the social acts in which they arise and which they express, are being "infected" (Smith, 1999) through and through with business-like interests. I describe how the nursing discourse is reflexively (re)producing a specialized disciplinary language that has developed through synchronous conversation with a political agenda of fiscal restraint. I argue that the evolution of nurses' use of language creates an illusion that nursing care is proceeding "as usual" in the interests of patients and their families. However, in nurses' actual practices and through this evolving use of language, a managerially-oriented form of nursing care is being shaped (that is spoken, written and read about) that redefines how nursing care is described, produced and judged.

Conclusion

In my concluding chapter I reflect on my discoveries about the health care reforms in Canada that I have argued systematically create troubles for nurses and their patients. According to the official accounts of restructuring, nursing practice is either unchanged

or improved by the implementation of management technologies, the re-engineering of work organizations and the redesign of hospital administrative structures. In this concluding chapter I reiterate my strong contention that this simply is not true. Nurses' practices *are* changed. When knowledge of health care becomes tainted, constituted in the image of managerial decisions, a serious threat to health ensues.

Finally I consider the implications of the analysis and argument I have presented. Issues of "accountability", as well as the burgeoning interest in conflict management, and the directions being taken in nursing education are all implicated. I draw on my own work as a nurse educator as I make suggestions for how to equip nurses to resist the subjugation of their knowledge of caring. I consider what this resistance might mean for nurses and how nurses might use my findings to subvert the restructuring of their practices. I consider strategies for provoking a nursing movement that is informed through theorizing nursing science as a socially organized body of knowledge and how nurses may become skilled at explicating the socially organized character of their practices.

Chapter One

Troubles in the everyday/everynight world of nurses: The problematic of the inquiry

Introduction

The process of unravelling nurses' problematic (Smith, 1987) begins in the everyday/everynight world of things happening in nursing. My role as a researcher is to explicate the qualities and conditions of nurses' everyday experiences that are often not visible, nor fully understandable from within the experience. Reflexively, nurses are both *within* the experience looking out, but they are also *of* the experience: formed by and making it, as they put it together. Concerning everyday experiences, Smith writes:

> If we cease to take them for granted, if we strip away everything we imagine we know of how they come about (and ordinarily that is very little), if we examine them as they happen within the everyday world, they become fundamentally mysterious (p. 92).

In this chapter I use ethnographic data to display some of the puzzling aspects of nurses' activities, and of things going on in hospitals, that take a central place in my analysis.

I detail three "vignettes" from my participant observations. To start, I describe an account about a group of nurse activists who expressed concerns about the care patients were getting at their hospital. Very early in my research I became associated with this group of nurses who were convening meetings to discuss troubling aspects of their practice. I relate here how I noted contradictory twists and turns in their thinking and actions as they attempted to unravel and to act upon serious issues related to their work with patients.

Secondly, an opportunity for participant observation arose during a personal encounter I had within a restructured Canadian hospital following the accident of a close family member. My aunt was hospitalized with an acute head injury following a fall from a ladder. She received prompt and impressive access to urgent medical intervention that included transportation by air ambulance and ready referral to a neurology specialist and an MRI (Magnetic Resonance Imaging). Nonetheless, there were occasions during this experience that were both troubling and puzzling and deserving of further study.

The final account I detail in this chapter is of a nurse at work in a restructured Canadian hospital. This opportunity for participant observation occurred when I was completing "clinical update" in my role as a nursing instructor.[4] It provided me with the opportunity to observe an instance of nursing practice that piqued my curiosity because, although it was an occasion of an apparently unremarkable patient discharge, it directs attention to a contested terrain of nursing practice that may not be obvious within the taken-for-granted frameworks of nursing work.

The three accounts direct attention to my research "problematic". As stated in my introduction, in institutional ethnography "problematic" is a technical term used to "direct attention to a possible set of questions that may not have been posed or a set of puzzles that do not yet exist in the form of puzzles but are 'latent' in the actualities of the experienced world" (Smith, 1987, p. 91). As a methodological approach, the research

problematic identifies points of "disjuncture" (Smith 1990b p. 83-104) in the everyday world. Each of these accounts has a disjuncture, a contradictory twist that I point to and elaborate as a puzzle to be explicated. Throughout this dissertation, the problematic I outline here is used as a methodological strategy for discovery; it is integral to my research protocol. In the ensuing chapters of this dissertation I come back, time and again, to the stories I introduce here examining them "from the inside out" (Mueller, 1995, p. 106).

Nurses United For Change – An account of nurse activism

Becoming involved with a group of nurses who were experiencing some disruptive effects of hospital restructuring gave me the opportunity to hear, first hand, about their concerns. The nurses referred to themselves as Nurses United for Change (NUC). They met as a group for the first time in 1996. They continued to meet on a regular basis until 1999. During this time, their hospital underwent a series of managerial restructurings, in which the "Nursing Department" evolved into a "Department of Patient Services" and then into its current form known as "Integrated Programs".

Throughout my involvement with the NUC group I heard many compelling stories about incidents in these nurses' practice where things had "gone wrong". I heard a story about a patient who had inadvertently been sent home with vaginal packing in place. I heard a story about a nurse who was unable to contact a physician to report a critical change in her patient. I heard a story about a nurse who was told to "try and cope" when she notified her patient services director that only two of the four nurses scheduled to work had reported for duty. And of another, similar situation, when an administrator advised a

nurse to "try and just do the basics" when the ward had six patients who were admitted on stretchers located in hallways and alcoves. I heard harrowing stories about patients who, according to these nurses, became seriously ill because of errors and omissions.

Initially, the nurses of NUC attempted to use established hospital processes to document troubling practice incidents. They used the formal processes available to them for addressing breakdowns affecting patient care. To do this, they used forms known as Quality Assurance (QA) forms that they submitted to the Clinical Coordinators of their units. Despite the fact that the nurses found completing the forms to be onerous and time consuming, they made a commitment to consistently document their concerns. They also made a commitment to encourage colleagues, not involved in NUC, to embark on a rigorous documentary process.

Regulations related to the QA forms required the nurses to complete the forms within 24 hours of the identified incident. Nurses often stayed late following their 12-hour shifts to complete the forms. The nature of the incidents commonly caused the nurses to miss their breaks, which compounded the accumulated fatigue and stress a shift of duty produces. Nurses would be anxious to get home to eat and to rest. The forms took about thirty minutes to complete depending on the complexity of the incident being reported. At the end of their shifts the nurses were exhausted and not inclined to make the effort the forms required of them. Among other things, this feature of the forms produced disincentives for nurses to participate in the documentary processes.

Over time, the nurses of NUC became frustrated by the apparent lack of response to the accumulation of their documented incidents. The nurses had submitted several QA forms documenting instances of severe skin blistering caused by a new product being used in orthopaedic surgeries (one nurse had eventually brought in a camera from home and had taken photographs of the blistering which she submitted with her QA form). Also documented on QA forms were recurring occasions when nurses had been unable to locate the anaesthetist on call for patients receiving Patient Controlled Analgesia. A QA form was submitted when a patient had a cardiac arrest moments after having been admitted from emergency with significantly compromised blood oxygen (PO_2) levels. A QA form had been initiated to document a serious blood transfusion error. A QA form had been used when a nurse had been unable to get a physician to attend to a patient whose neurological status was deteriorating – the patient had subsequently required emergency transfer to a large tertiary centre. A QA form had been submitted when a patient's reading lamp scorched through the bed linens and mattress. Increasingly disturbed by what they saw happening in their work, and the apparent lack of administrative intervention to remedy their concerns, the nurses of NUC placed their concerns about the QA process on the agenda of a meeting with nursing management. The agenda item read:

> ***Quality Assurance Issues***
>
> This is an issue of nurses feeling disrespected, not supported and not listened to. It is an issue of professionalism. Nurses need to feel they will not be victimized, marginalized or dismissed when they identify and document their practice issues. Specifically with QA forms, nurses need to understand the process the form enters, they need to hear back when they document concerns and they need to feel that nursing management supports

> the staff nurse standpoint in QA issues. Nurses need to feel supported when they identify QA issues that involve physicians or other hospital departments. Currently there is an utter lack of response; on the rare occasions when a response has been elicited, it is threatening and inflammatory (NUC agenda, May, 1996).

What I noticed here was how the focus of nurses' concerns about patients (things such as blisters, a patient's cardiac arrest and a transfusion error) had changed from the way nurses talked in meetings. Instead of the actual patient care concerns, discussed at length at NUC meetings, problems with the QA forms dominate. The nurses' worries about where the forms go, how they are used (or not), and a nurses' experience of being harassed by a physician following her submission of a QA form, are the focus of this agenda. The agenda items developed for the meeting with managers directed attention away from what the nurses had discussed in their early meetings in one another's homes. The QA forms themselves take over as the focus of attention.

At the joint management meeting where this item about QA process was discussed the nurse manager addressed the nurses' concerns about QA. She explained how the QA processes worked. She described the categories that the QA forms are entered into and how each category is processed. She worked to reassure the nurses. She clarified that the process is not designed to be punitive but is a system to track and ensure quality care. Minutes taken during this 1996 meeting identify that:

> Lorraine (the manager) discussed the QA process –
>
> 1) QA's related to med errors/falls – Incident reports are not meant to be punitive but rather a means to track problems and ensure quality care. The QA goes to the CC/CN (clinical coordinator/charge nurse) who notes the recommendations, if any. This needs to be completed within 24 hours. The QA then goes to the PCM (patient care manager) who checks if the audit is complete. Patterns are looked for and stats are tracked.

> 2) Doctor related QA's – The RN documents for the CC to follow-up; then it goes to the PCM for follow-up; then it's acted on by chief of staff; this leads to a response and trends to be noted. Dr. follow-up can take 6 weeks to 3 months.
>
> 3) QA memos related to burned mattresses and pillows – Again, need to be completed within 24 hours. Maintenance has been made aware; new bed lights have been evaluated; results went to maintenance, new lights have been ordered from capital equipment (Minutes, Joint Management Meeting, May, 1996).

The QA process is reinforced as a way the nurses are to respond to nursing problems such as the ones they spoke about in their meetings. Nurses write up their troubling practice stories on QA forms and enter the QA process. This process is intended to "track problems and ensure quality of care". Certainly, in the instance of the burned mattresses and pillows, the nurses are reassured that new lights have been ordered. The manager takes the opportunity to explain to the nurses that she has acted and will continue to act if they follow the QA process precisely. The "puzzle" I am displaying here is how the nurses' stories, and the serious incidents they had been documenting, somehow seemed to disappear within the boundaries of the QA process. The incidents become administratively categorized to be remedied through a strategic process that involves both the nurses and their managers.

As they discussed their concerns with their patient service directors, nurses' own good practical knowledge about what was going on in their work got lost. The nurses' worry that something was happening that was disrupting their practice went astray. The QA process described here, for the most part, did not produce useful solutions to these nurses' problems.

Indeed, the nurses' compelling stories were contradicted in an official report submitted by an external nursing review that was conducted during the early period of NUC's work.[5] The nurses of NUC secured a somewhat contentious private audience with the reviewers. Although NUC related many of the same incidents they had been telling during their meetings, in one another's homes, the reviewers summary report found that: "overall the consultants were impressed with the high quality of care provided and the effectiveness of resource utilization throughout the department" (External Nursing Review, June 19th, 1996). Although the review was ostensibly specifically commissioned to "assess the impact of restructuring on the nursing department" – the same restructuring the NUC nurses were finding so distressing – the NUC nurses' specific and disturbing tales did not find a place in the reviewer's findings. A single reference that may or may not have referred to the matters raised by NUC was a statement identifying that: "some units within the hospital are having more adjustment problems than others" (External Nursing Review, June 19th, 1996).

From 1995 to 1998 the NUC group were involved in numerous meetings and activities with various levels of hospital administrators and reviewers. Throughout this time the nurses of NUC believed that the issues they were raising were not being addressed in any substantial way. In 1998, following a controversial public submission to the regional health authority, where NUC involved local media, the nurses seemed to garner serious administrative attention. More meetings were held where their issues were discussed. Nurses were given "release time" to attend these meetings and air their concerns. Finally

a private consulting company was contracted to initiate a formal process of conflict resolution.

At the start of the NUC process, the nurse activists with whom I was associated were very clear about what the patient care problems were about. Thinking back on what I was hearing from the NUC group toward the end of the process I could see that their focus had shifted. At first they had discussed heavy workloads, novice staff, lack of clinical leadership, doctors who were not available or not responsive to nurses' concerns about patients, faulty equipment, lack of pharmacy support and so forth. By the concluding episode of the nurses' activism, their concerns became constituted as interpersonal. Ultimately the NUC nurses' work focussed on impugning characteristics of their *relationships* with managers, their many stories about patient care being jeopardized were not addressed. While many of the nurses' troubling stories had an interpersonal component, the stories also contained significant material features about the nurses' work setting that were much more complicated than mere issues of "interpersonal conflict". Nevertheless, representatives from the NUC group attended several gruelling sessions of "conflict resolution" that were held in conjunction with a process of "team building" and "leadership workshops". The administrative response to the issues raised by the nurses of NUC (and indeed, even the activities of the NUC nurses themselves) consistently diverted attention away from the issues of patient care. It seemed to me that the attention paid to "conflict resolution", team building and workshops to develop leadership skills were a way of controlling the NUC nurses' activities.

Following the conflict resolution process the nurses became fatigued and disheartened. The NUC nurses ceased meeting on a regular basis.[6] Wearying of the grind of general ward nursing, many of the original members of NUC moved on into other nursing roles and specialty areas of practice. Contacted in 2003, most original members of NUC believe that, in spite of their political activities, in the intervening years, they have experienced unabated deterioration of the conditions of their work across varied sites of hospital practice.

An urgent hospitalization: An account from a patient and family perspective

Another story illuminates something about how patients are also having troubles in the restructured hospital. An accident that befell my aunt Hannah offered me a view, from a changed vantage point, about what is happening to patients. I now move into an account of Hannah's hospital experiences, and mine, as I provided her bedside attention. Hannah's and my hospital experiences and the events that followed are presented as another instance where I illuminate a puzzling disjuncture, not readily noticeable until our activities are scrutinized.

After Hannah's accident I spent many hours at her bedside and, as a nurse, I was more active in her care than a non-professional family member would have been. Throughout the hospitalization I made numerous observations of the nursing care Hannah was given that, in my professional opinion, led to complications in her recovery.

Hannah was experiencing low serum sodium (a not uncommon response to a severe head injury). As a result she was placed on a fluid restriction of 800 millilitres a day. During this time there was minimal nursing attention to measure Hannah's fluid intake or her urine output. There was an "Intake and Output" record posted by the door to her room, but the staff picking up her meal trays, or cleaning the cups away from her bedside were not professional nurses. Information about her intake of fluids was routinely missed. Likewise when Hannah went to the bathroom, she was seldom assisted by the same nurse twice, and no one was monitoring the volume of her urine.

I had concerns about what the lack of nursing attention to Hannah's fluid balance meant for Hannah's health. At the same time Hannah's fluid intake was being severely restricted, she was also experiencing a virulent bladder infection. On one occasion, during an afternoon visit, Hannah mentioned to me that she had not urinated since early the previous morning (approximately 32 hours ago). The "Intake and Output" record had nothing written on it for the previous 24 hours. I assisted my aunt to the bathroom where, with appropriate "nursing intervention" (running water, reflex stimulation, privacy etc.) she passed 900 millilitres of very foul, concentrated urine. The inattention to her intake and output, combined with a severe bladder infection and fluid restriction, meant that this important component of her daily (specialized/nursing) care had been omitted. Hannah's overly full bladder may have contributed to her persistent fever, her overnight restlessness (and subsequent physical restraint), and her mild confusion.

Lack of attention to Hannah's fluid consumption and her urine output may also have contributed to serious heart irregularities. On a second occasion of Hannah's overly full bladder being overlooked, unlike the somewhat benign outcomes I have described from the first occasion, Hannah required urgent transfer to a cardiac intensive care unit. Hannah has a cardiac condition known as "paroxysmal superventricular tachycardia". Prior to her accident, Hannah's cardiac condition had been stabilized with medication. On this occasion, the noxious stimulus of Hannah's overly full bladder most likely contributed to the triggering events that caused her normally stable condition to become unstable. An intensive care nurse detected the full bladder shortly after Hannah had been transferred into the cardiac care unit. This nurse inserted a urinary catheter and drained 1000 cc of urine from Hannah's bladder. Hannah's serious cardiac arrhythmia did not respond to three attempts of cardioversion with electrically charged chest paddles. Eventually she was placed on intravenous Amiodarone (an anti-arrhythmic). In the meantime she suffered abrasions on her chest as a result of the cardioversion attempts. This potentially avoidable situation seriously jeopardized Hannah. It also contributed to her overall discomfort and suffering.

I was with Hannah on the neuroscience ward early in the morning, when her arrhythmia developed.[7] That morning, the nurse caring for Hannah was a novice, casual employee. He seemed overburdened with the needs of the patients in Hannah's four-bed ward. When I called him to report my Aunt's racing pulse and her complaints of feeling "woozy" he was completing his night shift. He did not assess Hannah. Instead he informed me that he had just taken Hannah's vital signs and that she was fine. I quickly

located a stethoscope and, upon finding Hannah's blood pressure had dropped significantly, I was able to convince this nurse to call a doctor. Throughout my experiences I was aware that nurses seemed to be irritated, or possibly intimidated by my vigilance. This was a disconcerting experience. My own beliefs and training directed me to be a "good family member" I stayed out of the nurses' way as much as possible. Yet, as in this case, I drew to their attention issues I thought they would want to know.

Three months following Hannah's discharge from hospital we were mailed a package of survey materials entitled "Through the Patient's and Family's Eyes". The surveys invited us to give feedback about our hospital experience. The survey asked 127 questions under ten categories such as: Communication and Relationships, Your Daily Care, Preparation for Discharge, and so forth. Generally the questions offered forced choices in such categories as Strongly Agree, Agree, Uncertain, Disagree and Strongly Disagree, or Excellent, Very Good, Good, Fair, and Poor. Both Hannah and I willingly participated in the survey. We thought it was important to give feedback about "how (the hospital staff) are doing" as the survey's introduction queried. We had things to say, both appreciative and critical, that would help in the hospital's undertaking to "improve the delivery of health care to you and your family" (from the survey introduction). We completed the surveys together, consulting with one another, and remembering the hospital experience. We were interested in providing an accurate account.

Completing the surveys (one for completion by the patient and other intended for "the family member most involved in your hospitalization") was not a straightforward

endeavour. Hannah's experience of her urgent, late night, air evacuation combined with her altered level of consciousness made it impossible to answer the survey questions about her admission and orientation. I too, could not answer and was not interested in many of the questions on the survey that were not relevant to our experiences. For instance, it was not relevant to me whether or not we received information related to the hospital daily routine and whether our perception of the admitting process was "poor" or "excellent". My needs in relation to Hannah's hospital admission revolved around making my own air travel arrangements, and, upon my arrival, trying to find Hannah in the large metropolitan hospital. I recall getting lost when I got off an elevator in a corridor flanked by two doors; each door marked "authorized personnel only". Also, during these early hours of Hannah's hospitalization I was frustrated in my attempts to get information about her condition or test results.

I puzzled about how the survey's 127 questions, with the prescribed choice of responses, could hold the things Hannah and I wanted to say. In the survey, under the heading "Communication and Relationships" we both wanted to tell about how information related to Hannah's significant sensitivity to the drug nitroglycerine had not been passed on among the doctors and nurses caring for Hannah. Information about Hannah's pre-existing medical conditions had somehow been lost. Twice, Hannah was given nitroglycerine for complaints of chest pain, both times occasioned urgent medical intervention to support the sudden drop in her blood pressure. We would also have described the time when a cardiologist asked me to leave the room, and while he was examining Hannah he mistakenly asked her about a heart surgery she had not undergone.

In view of Hannah's head injury and related speech difficulties this was a disconcerting and troubling experience with potential for serious error. None of these critically important details about what actually happened, things Hannah and I wanted to volunteer about the hospital experience, found a place in the patient satisfaction survey tool.

Hannah completed the section of the patient satisfaction survey form relating to "daily care" in a manner that indicated she was "completely satisfied". It was in this section of the survey that my knowledge, developed through professional education and experience, disputed my aunt's views. The responses my aunt and I made as we completed patient and family satisfaction surveys did not hold the stories we had to tell. The information being produced subordinated any concerns either Hannah or I had about "what actually happened".

Nonetheless, in the contradictory twist I point to here (and elaborate upon throughout the dissertation) patient satisfaction survey results are used to constitute strong evidence of patient's and family's views (CIHI, 2000). Through patient satisfaction data Canadians are "reassured", that "Despite polls that reveal the lowest ever public confidence in health care, surveys demonstrate that Canadians have consistently high levels of satisfaction with the health care they receive" (Macleans Magazine, 1999, p. 24). In patient satisfaction surveys, what is actually happening to nurses' work within restructured Canadian hospitals is rendered unavailable for administrative action. What this means within a reformed health care system is something my inquiry addresses.

The discharge of a post surgical patient: An account of routine nursing practice

The third account I detail here is an occasion of practice in which I actively (formally) participated as a nurse. It occurred during a morning when I was doing "clinical update" a component of my teaching work. In the course of my update I became involved in activities that offered an entry point for an analysis of how nurses' work is organized in restructured hospitals. This episode, routine and insignificant among the experiences that nurses discuss as contradictory and troubling, nonetheless, revealed a puzzling instance of how hospital restructuring has various impacts on the practice of nursing.

The activities under analysis occurred while I was working beside a Registered Nurse (Linda) on a busy medical/surgical ward. Linda had been assigned to nurse all the patients occupying the eight beds designated as "Team Two". Linda was assisted in this work by a Licensed Practical Nurse. Our primary morning tasks revolved around administering medications, assessing patients, getting patients ready for breakfast, assisting patients to wash, making beds, changing bandages, monitoring intravenous drips, and assisting patients to be mobile. Frequently Linda was called to the desk to respond to phone calls from a patient's family or friends, physicians, and staff in other hospital departments.

I recognized that Linda was engaged in thinking, planning, prioritizing and making decisions about what needed to be done and when. Later, in an interview, I asked her to explain this to me. Linda talked about how she made some of her decisions. She

explained why she monitored certain patients for certain symptoms (for instance, why she assessed the "ortho-vascular signs" of a woman with a hip fracture, and why she decided to administer an aerosol medication to a person with lung disease before the directed 10 a.m. time, due to the patient's increased breathlessness). Linda's talk displayed some of the professional knowledge relied upon as she went about her work.

Ms. Shoulder was a patient occupying one of Linda's eight beds. She was an otherwise healthy, middle-aged woman who had undergone a repair of shoulder ligaments the previous day. Shoulder surgeries (rotator cuff repair) are allocated one overnight stay in the hospital and patients undergoing this surgery are generally discharged the morning following surgery. Discharge arrangements are made well in advance of the surgical procedure and are discussed with the patient during a pre-admission appointment in the pre-admission clinic.

Ms. Shoulder had spent an uncomfortable post-operative night. She told Linda that she had slept poorly. The nursing care she required focused on the large "shoulder immobilizer" she was wearing. The shoulder immobilizer is a type of sling that is worn for six weeks after the surgery. It prevents the patient from "abducting" the shoulder joint (the arm is maintained in a snug position, close to the body; any movement away from the body is to be avoided). Having one arm thus disabled created some challenges for Ms. Shoulder's ability to wash and dress. Linda placed a chair in the bathroom and provided Ms. Shoulder with a towel and washcloth. Ms. Shoulder was instructed to wash what she could and told that we would be back later to assist her to get dressed. Upon our

return 20 minutes later Ms. Shoulder's face was pale and her skin was clammy. She had managed to wash her hands, her face and her crotch but was complaining of severe discomfort in her shoulder and stated she was also "queasy". Linda left to get some pain medication and I assisted Ms. Shoulder back into bed. Linda administered the pain medication (two Tylenol # 3) and inquired about when Ms. Shoulder's husband would arrive to take her home. Linda also proceeded to do the "discharge teaching" related to the shoulder immobilizer. Linda then went away to attend to her other duties directing me to remove the bulky surgical bandage and replace it with a lighter one. Also I was to assist Ms. Shoulder to dress and prepare her for discharge. Getting dressed was a complicated, lengthy (15minute) process. Ms. Shoulder required help putting on her underpants, slacks, her shoes and her socks. She was unable to wear her bra and needed help to drape her blouse around her operative shoulder and stretch it across her chest to do up the buttons. She needed help with all the buttons. Once dressed, she appeared fatigued and very uncomfortable. She continued to complain of nausea and at one point I assisted her into the bathroom where she experienced a brief spell of the "dry heaves". I left her resting in bed and went to find Linda.

I found Linda in the "Same Day Admission Room". This is a room not occupied by a bed, and not officially part of Linda's eight-bed assignment. Linda was preparing a patient (Ms. Leg Wound) to go to the operating room for the surgical procedure of "debridement and application of split thickness skin graft" to a large open wound on her leg. Ms. Leg Wound had been hospitalized previously following a motorcycle accident. She had been discharged into a home care program. Her deep leg wound had not

responded to the prescribed wound care regime at home, and now more aggressive surgical intervention was indicated. Ms. Leg Wound was in a wheelchair with her injured leg elevated. Linda was going through the chart checking for a signed surgical consent, looking at lab results for particular blood tests, and reading through the physician's orders. Linda was also conducting a short "pre-op" interview, (last time to eat or drink; last time to urinate etc.) and ticking these details off on a checklist. She took the woman's vital signs and assisted her out of her clothes and into her hospital gown. The physician's orders included directions to "compress the wound preoperatively". Linda was required to unwrap the bandage, assess the wound, place a large salt-water compress over the wound, and document a description of both the wound and the treatment.

I interrupted Linda during these duties to report the condition of Ms. Shoulder. Linda stopped her work with Ms. Leg Wound and hurriedly checked to determine if Ms. Shoulder could receive any medications to control her nausea. There was no physician's order authorizing her to administer an anti-nausea medication and so Linda, glancing at her watch (and seeing that it was close to eleven o'clock, the assigned discharge time) made the decision to administer an antacid stating she "hoped it would help". Ms. Shoulder's husband arrived to drive her home. Ms. Shoulder was given a prescription for "Tylenol with codeine" (painkillers) and also advised to purchase some "Gravol", (an anti-nausea drug) on the way home. She was given a small cardboard tray in case she vomited in the car. She was then discharged at the required eleven a.m. check out time, looking decidedly unwell.

This is the contradiction I would like to draw attention to here: How did it happen that Linda and I (both of us apparently competent, caring, fairly well organized nurses) did not choose a different course of action in our work with this woman in our care? How did it happen that we participated in activities that likely, within the professional body regulating our practice, would be held up for criticism? Of possible professional concern would be Linda's breaking of the rule about nurses administering a drug (the antacid) that has not been ordered by a doctor. Our practice might also be critiqued for not being ethical and for not meeting professional practice standards. Within the code of ethics established by the Canadian Nurses Association it states "Nurses provide care directed first and foremost toward the health and well-being of the client" (CNA, 2002, p. 4). Measured against this professional code of behaviour, Linda's and my practice could be found wanting. Our ad hoc solutions were not a course of action that reflected a priority for Ms. Shoulder's well-being. Furthermore, Linda's administration of an antacid for a patient's complaints of nausea, unrelated to acid reflux disease, did not reflect "competent application of knowledge" about pain and nausea. In this situation, nursing actions that demonstrated compliance with professional codes and standards would have seen Linda and I phoning the physician to obtain an order for anti-nausea medication. We would have administered the anti-nausea medication. We would have assessed Ms. Shoulder to ensure that the pain medication we had administered had time to work, that it was effective and was not contributing to her nausea. In addition, allowing Ms. Shoulder more time to sleep and offering her breakfast and a wash later, would optimize our care for Ms. Shoulder. This strategy would increase Ms. Shoulder's ability to be receptive to

the important instructions we gave her and also contributed to her comfort and her ability to cope with going home.

If Linda's practice is ***not*** organized by or oriented to professional codes and standards, what ***is*** the organizing principle or focus? My analysis is motivated, not to criticize, but to understand how Linda and other nurses working in contemporary hospital settings find their work "organized" outside their control, and thus, how they find themselves unintentionally subverting the standards of their profession. The instance that I describe offers some insights when used as an entry point to explore the actual organization of the nursing work process.

Arriving at a problematic for inquiry

The research problematic I bring into view identifies a contested definition of competent nursing practice. My informants from NUC and my own observations related to the discharge of Ms. Shoulder and the care my aunt received during her hospitalization reveal that within health care reform and hospital restructuring, something is disrupting nursing care. Sometimes, nurses experience and describe this as troubling. And yet, in the official monitoring of competent/satisfactory practice being used to evaluate restructuring, this disruption is not showing up. In fact, as in the nursing review conducted at the NUC hospital, changes to the nursing department are demonstrated to be a progressive change. Furthermore, many nurses themselves view the new programs and initiatives of hospital restructuring as necessary for the production of hospital services.[8] In many of my discussions with nurses about changes in the delivery of hospital care their critique centred on how to improve the new programs to make them work better,

rather than on an empirical analysis about how the restructuring may have changed the face of their nursing, or, as I am suggesting, how nursing "competence"[9] is now being shaped differently.

The accounts I have detailed provide a place for me to start looking at the issues at hand through the lens of an institutional ethnographer. This experiential data becomes the entry point of the analysis to the social organization of hospital restructuring and health care reform. My research leads me to investigate "what actually happens" when work processes *and* nurses' responses to troubling practice issues are (re)organized through health care reform and hospital restructuring. How did the nurses of NUC get caught up in the troubling disjuncture that rendered their issues "interpersonal"? In the hospital where my aunt was treated, how were our troubling experiences with her daily care organized? And how do these experiences get "worked up" in such a way that Macleans magazine (1999) can make the claim about the consistently high level of satisfaction Canadians report? How did Nurse Linda know she must proceed with Ms. Shoulder's eleven a.m. discharge? How are nurses organized to adapt their work processes to new efficiencies? I am interested in what gets included and what is left out of nurses' work as it is reorganized to conform to the demands of the restructured hospital. My research begins, not in the objective domain of health administration or nursing management theory but "with the everyday events in peoples' lives, and in their problems of knowing – being told one thing, but in fact knowing otherwise on the basis of personal experience" (George Smith, 1995, p. 21).

My approach to these questions relies on the theoretical framework of institutional ethnography, which focuses attention on social relations, as opposed to individual actions and competence. The problematic is foundational to my approach to this research, which seeks to answer the larger research question: "How do nurses practise health care reform and hospital restructuring?" My research arises out of data about nurses' and patients' everyday experience, which I use to point to disjunctures that arise, that separate everyday/everynight knowledge about what is actually happening on the ground among nurses and their patients, from the bureaucratic domain of hospital restructuring. Understanding how the bureaucratic world of hospital restructuring is organized is the first step in learning about how a nurse (such as Nurse Linda of my problematic) makes a "nursing" decision that does not take up her patient's problems. How do nurses mediate between an abstract world of "quality assurance" and what actually happens in their work with patients? How is nursing "professionalism" tied into the new accountability structures?" How are professional relationships changing? How does it work? How is it put together?

I turn now to the theoretical and analytical basis for examining these data to situate these accounts about what is actually happening in the everyday/everynight world of hospitals within the contemporary organization of the Canadian health care system, which, over the past twenty years, has been reformed and restructured. In the following chapter I frame my inquiry within the discourse discussing health reform, hospital restructuring and its impact on nurses. This is followed by a chapter in which I detail how I use Dorothy Smith's "alternate sociology" and her theoretical writings to inform the ontological shift I

use to investigate, empirically, the social organization of nurses' everyday/everynight experiences of their work.

Chapter Two
Canadian health care reform and hospital restructuring: Setting the context

Introduction

This chapter offers the context for my analysis of the current reforming of the Canadian health care system. Here, I review and appraise a comprehensive, but by no means exhaustive, list of publications to display the themes and trends in the contemporary management of Canadian hospitals. Over the past twenty years, "developed countries around the world have been instituting health sector reforms in an attempt to reduce rising expenditure" (Finlayson and Gower, 2002, p. 28). "Sweeping changes" is what Leduc Browne (2000, p. 38) sees has been happening in the Canadian health care system. Within the mandate for social reform, health service delivery is being massively restructured. The twenty-year history of policy reform and organizational restructuring provides the context and the thorny issues within which my inquiry is set. The literature I review discusses these changes and makes it possible for me to distinguish the terms "reform" and "restructuring" that are often used interchangeably. Using this literature, I outline the development of health management technology, highlighting the current trends in hospital reorganization and methods of producing and utilizing "health information". I have approached the health management literature as a "set of instructions" for managers, and increasingly, for front line workers who direct actions and activities to produce efficiencies in the operation of the health care setting.

Health Care Reform

Reform is the term most often used to indicate the broad changes planned, taking place or already accomplished within the macro-political legislative arena of the Canada Health Act and its Medicare program. Dickenson (1996) emphasizes this macro-political context, saying that "health reforms (are) driven by the neoliberal imperative of public sector health cost containment and the expansion of market-based health care delivery" (p 187). Gustafson (2000) sees health care reform as "the dynamic interplay among economic changes, the role of the state, institutional discourse and practices, and social reproduction within the public and private spheres" (p. 15). Leduc Browne (2000) describes "profound changes to health care services" (p. 77) pointing to major legislative initiatives in Ontario which entrenched a policy mandate to achieve fiscal savings through public sector restructuring. For Kerr, Glass, McCallion and McKillop (1999) the key objective of reform has been "to ensure [that] maximum benefit is obtained from available resources. . . two central aims can be identified for managers and policy makers: (1) to improve efficiency in the use of resources and (2) to develop health care services of an assured clinical quality" (p. 639). These analysts make it clear that health care reform has been driven by the political economy and focus on reductions in social spending. In Canada various levels of government have scrutinized health care expenditures in their efforts to eliminate budget deficits and balance their budgets.

Another theme of health care reform, according to Dickenson, (1996) is a "health promotion framework with its goal of achieving health for all [that] does appear to be a progressive countervailing tendency" (p. 252) to the various governments' fiscal restraint

initiatives. Reform efforts cluster around "primary health care" and "population health" initiatives. For instance, Finlayson and Gower (2002) identify the benefits of "reform efforts [that] have been made to move health services away from hospitals and into primary care" (p. 28). In discussions about health reform in Newfoundland, Nova Scotia, and Ontario, Botting (2001), Clow (2000), and Leduc Browne (2000), recognize and applaud population health and primary health initiatives that shift health care spending priorities from curative to preventive services. Several analysts, however, are critical of the trend to move patients and dollars out of the institutions that are insured under the Canada Health Act (hospitals) into those which are not (home care) (Fuller, 1998; Leduc Browne, 2000; Armstrong, Armstrong, Bourgeault, Choniere, Mykhalovskiy and White. 2000). In the Ontario model, as seen elsewhere across Canada and indeed, internationally (see Romanow 2002; Powell and Wesson, 1999; Armstrong, Amaratunga, Bernier, Grant, Pederson and Willson 2001; Finlayson and Gower, 2002), the investment in community health services and primary health care is often believed to be the way to reducing overall health care expenditures per capita. Purkis (1997) writes about the contemporary nursing discourse of "health promotion" that has arisen throughout the years of health care reform. She is critical and challenges nurses' ability to produce "health promoting possibilities in existing practice settings" (p. 47). For most analysts, funding structures and primary health care initiatives converge to produce the defining context of Canadian health reform which is being accomplished by organizational restructuring.

Restructuring of Health Care

Restructuring of Canadian health care has been accomplished through a broad set of strategies that are changing how health services are funded and administered.

Fundamental changes in the way hospital care is delivered is a theme in the writing of Finlayson and Gower (2002) who recognize that health care reform is "changing the way services are provided and reorganizing the staff who provide them" (p. 29). Tupper (2001) emphasizes the administrative character of health care reform claiming that a "multifaceted administrative revolution has transformed Canadian government. It involves the restructuring of government agencies, the creation of many new ones and the elimination of others" (p. 143). In speaking of an administrative revolution Tupper draws attention to the organizational context of health care that must be and is being restructured to accommodate reforms. Administrators of publicly-funded hospitals are challenged to develop new approaches to health care delivery that demonstrate efficient and accountable use of limited resources. "Common initiatives have involved hospital restructuring, downsizing, merging and closures" (Burke and Greenglass, 2000, p. 1013).

A focus on restructuring is a contemporary phenomenon not restricted to the reform of health care organizations, as McCoy, (1999) explains:

> We are at a time of significant restructuring in the way the public sector and the delivery of public services in Western nations are organized. This takes many forms, including direct cuts in funding and services, deregulation, privatization, new ways of managing the work processes of public sector organizations, and new relations of accountability, in which levels of funding are tied to reported performance (p. 1).

McCoy analyses how professional practices of accounting figure prominently in restructuring and explicates how "accounting methods provide a central resource in managerial efforts to identify and improve "efficiency" and "value for money" (p. 2). In public sector restructuring, the introduction of fixed new practices of accounting

coordinate new organizational facts and entities. McCoy notes how these processes "ripple through the work routines and sites" (p. 244).

Many health care analysts comment on the immensity of the changes taking place under the rubric of reform and restructuring. Bernier and Dallaire (2001) insist that traditional ways of delivering health care have been completely overturned by reforms. As an example they point to the altered site of much acute care: "The major thrust of the changes in the ways that services are delivered has been the shift toward ambulatory care, which has been accelerating since the mid 1990's" (p. 125). Norrish and Rundall (2001) also note that "the internal restructuring of a hospital typically includes the redesign of patient care processes and changes in workforce composition, organizational structure, decision making processes, and the responsibilities of management and patient care staff" (p. 55). Armstrong et al. (1994, 1996, 1997, 1998, 2000, 2001) argue that nursing practice and patient care is deeply changed through strategies of reform. They contend that "important aspects of skilled (nursing) care are lost in the new managerial strategies" and that "the systems are designed more to reduce costs and control providers than they are to improve continuity and promote quality care" (2000, p. 145).

Armstrong and Armstrong's (1996, 1997, 1998, 2000, 2001) emphasis is on privatization. They assert that health care restructuring efforts are "so fundamental in scope that they constitute a qualitative change, even a revolutionary one in health care provision" (2000, p. 1). McFarlane and Prado (2002) echo the Armstrongs' concerns about the immensity of change, suggesting that reform itself is responsible for a current crisis in health care.

They point to the "political capital and fifteen years of heartbreaking management effort"(p. 5) that has been expended to reform the Canadian medicare system, noting that the organizational restructuring that resulted from health reform initiatives were "not simply tinkering or fine-tuning; they involved the wholesale adoption of a completely new management model of health delivery" (p. 5). My research interest is in learning more about how all these changes affect nursing. In order to conceptualize how nurses and nursing may be involved, it is necessary to grasp their involvement in the range of activities involved in bringing this massive reform effort into hospitals.

Strategies of reform that organize hospital restructuring

Regionalization

Commonly hospital restructuring occurs within a "large scale change in the organization and decentralization of control" (Peterson, Cooper and Scherer, 2000, p. 609). In Canada many provinces and territories have regionalized their authority over health care. Lomas, Woods and Veenstra (1997) define decentralization as the "transfer to a local authority of some decision making within a significantly constraining set of centrally-determined guidelines and standards" (p. 373). Decentralization of health care administration changes how health care dollars flow into Canadian hospitals. Formerly, dollars flowed from provincial ministries of health directly to providers of services (ie. hospitals). With decentralization, dollars flow from the ministry to regional health authorities which decide how to allocate resources to widely diverse service providers including but not limited to hospitals.

Despite this broad emphasis on *regionalization*, hospital administration is being reformed through the *centralization of administration* across geographically dispersed hospital sites. For instance, within discrete geographical regions, local service providers are being "integrated". Regional health care corporations that achieve "multi facility management" (King, 1995) are able to implement administrative services such as payroll and human resources across several hospitals.[10] In a paradoxical twist, decentralization of ministry control over health services has been followed by the centralization of control over local agencies as they are amalgamated within large regional "corporations". For hospitals, this integration of services means that responsibilities for such things as planning global budgets, granting physician privileges, administering utilization and quality management, managing payroll services, bed and service distribution, and overseeing patient care services and so forth have been centralized (King, p. 114). The centralization of services is intended to produce a "flattened administrative structure" (Kruger-Wilson and Porter-O'Grady, 1999, p. 56) with reduced bureaucracy and fewer costs.

Privatization

Privatization of health services is a controversial strategy of Canadian health reform and hospital restructuring. Provinces differ in their political approaches to privatization. While Ontario and Alberta (and more recently British Columbia) support reforming Medicare to include the use of user fees or the development of a parallel private system of medical and diagnostic services, other provinces are more supportive of staying the current course of health care reform by increasing tighter controls and further centralizing authority (McFarlane and Prado, 2002). Despite legislative restraints entrenched within the Canada Health Act, across Canada, there is a move to a greater reliance on the private

sector as ancillary health services such as laundry, food preparation, cleaning, and maintenance services are being awarded to private contractors and "public-private" partnerships are starting to proliferate in diagnostic and laboratory services.

The trend towards privatization is a major focus of the critical analysis of Canadian health care reform. Many policy analysts are concerned about how "government funding cutbacks in a climate of deregulation and privatization suggest a likely corporate takeover. . . the changes underway are weakening the foundations of public health care" (Fuller,1998, p. xi). Leduc Browne (2000) discusses the context and strategies of "piecemeal privatization" in Ontario. He argues that unsafe practices have pervaded Ontario's health care system as hospital administrators have come to rely on private-sector business strategies. He criticizes the increasing reliance on hospitals generating their own funding sources (for instance leasing agreements with private franchises such as Tim Hortons' or Second Cup) and growing dependence on lotteries for capital equipment purchases. He also discusses some negative consequences of contracting out (privatizing) services such as laundry, laboratory, housekeeping, and food preparation.

Privatization of the Canadian health care system was a central issue in the 2000 federal and provincial elections and has been intensely debated in the popular press. Two highly publicized government commissions (Romanow, 2002, and Kirby, 2002) have been conducted to examine the future of Canadian health care with consideration of private hospital services and the establishment of a "two-tier" system of health care for Canadians. Debates in the popular press, such as Mcleans magazine's *Annual Ranking of*

the Best Health Care (1999, 2000, 2001, 2002, 2003), focus on what is happening to Canadian Medicare in the face of a federal Liberal agenda for "economic globalization, nation-state competitiveness, privatization, drastic funding cuts and strong support of free trade agreements (Barlow, 2002, p. 2).

Pat and Hugh Armstrong, collaborating with other authors (1996, 1997, 1998, 2000, 2001), have produced an extensive and important critique about privatization and Canadian health care and health care reform. With "strong roots in the labour movement", (Armstrong et al., 1996), their program of research and publication develops a critical stance to the current "medical model" of health care, and especially of the private sector practices being introduced as part of the reform of the Canadian health services. They produce a compelling argument outlining the impact of neo-liberal and market-oriented policies on both the quality of health services and the deteriorating terms and conditions of employment in health care work. Specifically they examine the "logic and results of cost cutting" (1997, p.16) criticizing the impact of bed closures, drug de-listing, and practices of contracting out hospital services. Armstrong et al. criticize the expansion of out-patient and day surgery programs that shift more responsibility for care to family members.

Several authors point to the gendered consequences of strategies to privatize health services. The arguments focus on the burdens faced by women when health care is transferred into the private sphere of the home, and also the consequence of increased work demands and the financial hardship borne by the predominantly female health care

work force when the work in hospitals is restructured. Armstrong et al.'s (1996, 1997, 1998, 2000, 2001) research offers first hand accounts about the "uncomfortable reality that a great deal of caring work includes hard manual labour, dirty jobs, sleepless nights and mental stress" (2001, p. 13). They provide a cogent discussion about the costs of this work, both to the women who deliver it, and to the people they are charged to care for. As women, nurses are implicated on both sides of the work transfer as closer-to-home policy initiatives transfer nursing work into the unpaid work of informal caregivers. Bourgeault and Angus (1999) analyze the "gendered structural relations between the professions and the state" (p. 83) and argue that despite pay equity policies, nurses (unlike doctors) have suffered economically as a result of the increasing role of state management and of the privatization that has occurred with health care reform and hospital restructuring.

Other authors who focus on the negative impact to women of the new business-like strategies reforming and restructuring health care are included in Gustafson's (2000) edited collection: *Care and Consequences: The Impact of Health Reform.* This collection produces a comprehensive analysis about how a business paradigm "works" in the production of Canadian health care and social services. Closely aligned with the approach my own inquiry takes up, many of the contributions to this collection adopt a research stance in the actual experiences and embodied practices of patients and their (predominantly female) caregivers (Gregor, Keddy, Foster and Denney, 2000; Spitzer, 2000; Cawthorne, 2000; Transken, 2000). The authors track the connections between experiences such as women in childbirth or women who require home care services into

the policy realm of legislative acts, health region policies, agency staffing protocols, criteria based assessment tools and so forth (Gustafson, 2000; Simpson and Porte, 2000; Esteves, 2000; Guruge, Donner and Morrison, 2000). A conclusion is drawn that:

> Over the past decade health care in Canada has shifted from a cure-care model to a business model. Disguised behind talk of community, closer to home, consumer choice, patient rights, cost-containment and improved efficiencies, the business model has ushered in "bottom-line" financial management which has brought us steadily deteriorating health care services" (Cover page).

Changes in how hospital services and equipment are being paid for and in how hospital services are being administered influence nurses and are thus of interest in my own research. In my inquiry I focus on nurses as they employ strategies from the business paradigm that are imported from profit-based industries. I investigate how such strategies are actually produced in the activities of nurses, patients and families, whose material work is relied upon to produce whatever efficiencies come about.

Funding

The flow of dollars into regional health authorities, *and* the health authority's methods of distributing those funds to the providers of local health services have also been subject to reform. The capacity to target funds and control expenditures is an important feature of the reform agenda. Provincial ministry policies and standards are part of the "constraining centrally-determined guidelines and standards" referred to by Lomas (1995, p. 28) in his definition of decentralization. A growing interest in reformed methods of funding was reported in *The Financial Management of Acute Care in Canada,* (McKillop, Pink and Johnson 2001) a document that highlights the increased importance for hospitals to generate and use health information data. Distributed by the Canadian Institute of Health Information, this report identified and contrasted information-based

(e.g., "population based funding" and "case mix group" funding with older methods for managing hospital funding). [11] [12] According to this report, provinces are moving towards population-based methods to apportion the majority of operating funds to regional health authorities (p. 89). Population based funding uses demographic characteristics to link the cost of providing health services to estimates of how frequently certain populations seek health services. The regional health authorities are moving to "case mix" funding methods to apportion funds among programs. Case mix group funding (CMG) provides funding formulas for specific groups of medical diagnoses. Patients are categorized according to their diagnosis. Data about "like cases" are aggregated and the mean cost per case is statistically generated. For each diagnostic group, standard length of stay criteria and other standardized measures of resource utilization are calculated. Under "case mix group" payment schemes, "hospitals are paid a predetermined amount per patient according to the patient's diagnosis, regardless of the length of stay and only moderately influenced by the services provided" (Roggenkamp and White, 2001, p. 1058).

Strategies of hospital restructuring that re-organize hospital services

As I have suggested, health care reform sets the agenda and hospital restructuring names the process of operational changes through which the health care system is being revolutionized. The strategies for hospital restructuring I review here are predominantly data-based managerial technologies. They are implemented through the health information architecture conceptualized, promoted and overseen by the Canadian Institute of Health Information (CIHI). Through this information infrastructure hospitals

are increasingly able to both implement and measure the successes of their own versions of health care reform.

Health care reform has a push and pull re-structuring effect. As described above, restructuring of hospitals takes place as policies initiated within a health care reform agenda are implemented. Given the push of this agenda, and the developing technical capacities of information technologies, hospitals are able to, and must, continually restructure their operations to improve their efficiency and effectiveness. They must also utilize the information technologies to *report* these improvements (accountability). The pulling effect is then exerted as activities of caring must be rethought and re-organized to take advantage of the new managerial technologies. It is within this restructuring process that my interest in the evolution of nursing practices arises.

Management technologies

Changes to hospital funding are emblematic of a new reliance on information for management (Giovannetti, Smith and Broad, 1999). Management and the activities and responsibilities of hospital managers are now being organized in relation to specifically generated information. Not just funding but all administrative activities are conducted in text. For instance, performance indicators make possible new managerial accountability structures. Managerial decisions that were previously based on direct supervision and interpersonal reporting practices are now being made in relation to the textual data being produced in health information systems. Faced with multiple demands – accreditation standards; competitive funding cultures and increased public and political pressures for "accountability in health care" – hospital administrators have had to learn about, and

develop, programs to track, measure and provide data to diverse groups of increasingly vigilant stakeholders. This area has been the site of impressive development, much of which has been adopted from the US and from the private sector (Grinspun, 2000). Management and information technologies have been designed to support administrators, bureaucrats and politicians in their efforts to apparently "establish sound health policy, manage the Canadian health system effectively and create public awareness of factors affecting good health" (Giovannetti et al., 1999 p. 305). Recently the Canadian Institute for Health Information (CIHI) has embarked on an ambitious national project of an integrated "health information" system for Canada (2000). The information thus generated is foundational for the introduction of an elaborate network of increasingly rationalist/information-based approaches to managing health care.

Information systems produce a capacity to scrutinize and adapt hospital operations – both clinical and administrative – to accomplish managerial efficiencies. The information systems, the data they produce and the restructuring they establish are overwhelmingly accepted as evidence of progress. Only a few analysts (referenced throughout this chapter) have focused critical attention on the contemporary reliance on management technologies. My next goal in this chapter is to describe the dominant technologies being employed by hospital managers and health administrators and point to what dissenters have observed. My aim is to unravel the elements of these approaches that other critics have recognized as troubling, but few have explicated.

Technologies to produce information about "quality"

Programs of quality assurance were among the first institutionalized efforts to measure a health care product "quality" using standardized methods. The task required both the construction of the product as data and then its measurement and comparison. The proposed formula for quality in hospitals is relatively unchanged since its formal Canadian introduction by the Canadian Council of Health Facilities Accreditation in 1983 (see Canadian Council of Health Services Accreditation 1995).

In the intervening decades, since "quality assurance" was first introduced to hospitals, technological change and increasing consultation with private industry have influenced the practices and scope of quality programs. Record keeping processes have become intensely computerized, linking and comparing a wide variety of data sets. Approaches to establishing documented standards of practice, and for measuring, auditing and reporting, have become increasingly complex. "The expectations that data will be linked, quality will be monitiored, and costs will be analyzed have been catapulted to the forefront of health-policy directives, and the needs of health professionals for timely, accurate, and easily accessible information at the point of care have become more urgent" Giovannetti, 1999, p. 298).

Importantly, now in the era of "reform", information highways that have been developed are able to link patient care with records of funding allocation, and the costs and expenditures of care provided. In 2002, the CCHSA accreditation process includes the indicator:

> The organization consistently provides service(s) in the best possible way given the current and evolving state of knowledge. The organization achieves the desired benefit for clients and/or communities with the most cost-effective use of resource (p. 25).

What began as a mandate for hospitals to produce "quality" data for the purposes of hospital accreditation is now part of much larger contemporary interest in generating health data to compare and control costs. In programs of quality assurance and quality improvement, "indicators" are selectively identified. The indicators are intended to evaluate patient care and to direct processes of improvement. Improvements are expressed in terms of improved efficiencies. The CCHSA mandates that "resources (inputs) are brought together to achieve optimal results (outputs) with minimal waste, re-work, and effort" (CCHSA, 2002, p. 29). As "quality" programs have evolved into "quality improvement", quality has been morphed into cost-efficiency. Campbell (1998a) identifies how contemporary "quality" initiatives support a work organization that make cost-efficiencies integral to each person's individual decision making and action. Campbell's investigation into a "service quality initiative" in a long term care setting explicates how the initiative appeared to compromise patient care by reorganizing individual caregivers' values and practices towards rationing costs. One example was the standards that caregivers adhered to for changing diapers. Within the new initiative, caregivers' actions were oriented to the costs of the diapers, not to the patients' needs.

In hospital restructuring, there is an interest in addressing factors of all kinds that may have some effect on health care success and that can support administrators in their efforts to establish sound approaches to making patient care in hospitals more (cost) efficient and accountable (Mykhalovskiy, 2001). The patient satisfaction survey I

described in the previous chapter is just one of the many accountability systems that have been built into hospital accreditation processes. According to the Canadian Council of Health Services Accreditation (CCHSA) hospitals are required to monitor "the subjective perceptions about quality by stakeholders such as patients and families" (2002, p. 12). Evaluation of patient satisfaction is a managerial technology intended to "focus on the patient" and to contribute to the design of hospital systems that measure, quantify and deliver "what patients really want" (Skelton Green, 1999, p. 6). All data demonstrating such things as patient satisfaction, must include analysis of improvement using standards and repeated measures over time (CCHSA , 2002 p. 237).

Indeed, whereas in the past management decision-making was based in actively learning about what was going on institutionally through direct observation, interpersonal, professional supervision and consultation, now the methods through which hospital and nursing managers exercise responsibility is achieved through management of data. Hospital accreditation processes that mandate the need to demonstrate "improvements" (demonstrated by applying standards and repeated measures over time) focus new and different attention on how hospitals are to be managed and evaluated.

The historical (twenty year) emphasis of hospital quality assurance programs has laid the foundation for the cost-focused restructuring of contemporary hospitals. Managerial expertise working with the "performance data" of the "quality" programs has established accepted methods and approaches as to how hospital restructuring is to be accomplished. The new interests of Canadian Council of Health Services Accreditation along with the

Canadian Institute of Health Information provide the incentive and the technical infrastructure to support the broad features of managerial restructuring in hospitals. They set the stage for the implementation and evaluation of programs aimed at improving (and evaluating) hospital efficiencies such as "patient focused care", "integrated health programs", "case management", "clinical pathways", "hospital/bed utilization programs" and patient satisfaction that I now briefly describe.

In identifying this varied collection of managerial strategies, I am drawing attention to managers and the managerial work involved in restructuring hospitals. Managers, who are working within the concerns that health reform introduces, take up the instructions and strategies outlined in the health management literature to implement methodical practices of decision-making based on systematically generated information. They produce information through what I refer to as "health management technologies". Use of these technologies introduces a focus on business into health care, reorganizing health care operations in relation to the newly available information on costs. Only in a hospital environment already restructured, with the capacity to generate systematic health care data, can these managerial technologies work and, through their use, they further restructure the health care setting.

Technologies to improve resource utilization

Kerr, Glass, McCallion and McKillop (1999) identified that improving resource utilization is one of the central aims of health care reform (p. 639). These authors explicitly equate satisfactory quality of health care with control over utilization and resource costs (p. 640). They highlight the need to identify "spare capacity" in order to

optimize resource utilization. In British Columbia, the B.C. Ministry of Health's Utilization Program, that according to the BC Health Management Resource Group (1991) was to be introduced into all B.C. acute care settings, focuses on measuring, accounting for, and rationing the broad use of hospital services.

According to the BC Health Management Resource Group (1991), utilization management is organized to take place at three different points of time, retrospectively through audits of health records, concurrently through ongoing "appropriateness of stay reviews", and prospectively through pre admission screening. Strategies to improve resource utilization promoted through the BC Ministry of Health include:

> Developing a same day surgery admit program; enhancing discharge planning, limited laboratory coverage to accommodate weekend testing; improving coordination and liaison between community home care support and education of physicians about these resources; involving patients and families more in care and planning discharge; having the Chief of Surgery review the long length of stay of patients and discuss with the physicians involved (BC Health Management Resource Group, 1991, p 6-10).

Such proposals are in line with accounts of the changes being introduced Canada wide. Programs developed to manage, measure and improve hospital resource utilization depend on categorizing and quantifying "inputs and outputs" (Kerr, Glass, McCallion and McKillop (1999). Hospitals service – "outputs" are frequently calculated through statistical analysis of data related to CMG's/DRG's. (Rosenman, Siddharthan and Ahern, 1997). "Inputs" such as "nurses" and "beds" are also defined and quantified. For instance, patient documentation may be systematically reviewed to determine that each patient "uses" the minimal amount of hospital resources. Indeed, there are packaged computerized software programs available that make it possible to conduct computerized

searches for patients who are nearing or exceeding the standard limit. For these patients, this sort of "flagging" may result in an expedited discharge (MCAP ^{TM} Oak Group, 1999, p. 1).

Technologies of Managed Care; Case Management

Technologies of "Managed Care" and "Case Management" are highly influential technological solutions that have been developed by the "Health Management Organizations" (HMO's) of the U.S. health care industry[13] (Grinspun, 2000). Managed care is part of a broad strategy to ensure optimum resource utilization, but it moves beyond just admission and discharge screening. Managed care and case management technologies provide a means to screen patients and ration their access to various diagnostic and treatment options (VanDeVelde-Coke, 1999; Smith, Danforth, and Owens, 1994). The Canada Health Act and the nature of socialized Canadian health care places some restraints on a wholehearted implementation of managed care in Canada. In Canada, utilization programs, care maps, and increasing emphasis on discharge protocols, are the strategies through which managed care's efficiencies are being implemented in a variety of adapted formats.

Clinical pathways and care maps

"Care maps" also known as "clinical pathways" or "critical pathways" are specific case management tools. They are one of the more pervasive strategies of managed care being instituted during the restructuring of Canadian hospitals. A care-pathway is a document directing and monitoring key interventions that must occur at timed intervals throughout a patients' hospitalization. Pathways have been developed for a wide variety of medical diagnosis and surgical procedures. A process is put into place whereby nurses are to

record whether or not the patient is following the defined standard pathway without incident or if there are significant variances (Windle 1994 p. 80K). Variances are documented in terms of delays and categorized as delays related to "the patient", "the system" or "the caregiver". Windle describes a care map implemented in a post anaesthesia unit as a "multipurpose six-page, three fold flow sheet" the use of which "improves patient outcomes, meets standards and facilitates easy tracking of a patient's progress" (p. 80F). Windle contends that the implementation of this tool proved "an effective process to control costs and improve patient outcomes" (p. 80F).

Much of the nursing literature on managed care and pathways is devoted to "success stories" (Capuano, 1995; Giuliano and Poirer, 1991; deWoody and Price, 1994; Perley and Raab, 1994; Brady 1998; O'Brian, 1998; Hay, Koegel, Teshima and Lewko, 1998). This literature, directed to nurses and nurse managers promotes strategies for integrating the efficiencies of managed care into the work practices of nurses, e.g., Cohen and De Back (1998). In restructured hospitals, the use of care maps accomplishes more than guiding nurses' activities. Care-maps are explicitly intended to integrate the work of nurses and allied professionals and to standardize activities across professional groups – in the interests of efficiency and effectiveness, frequently with the goal of increasing labour flexibility.

The expansion of managed care raises a number of issues (King, 1995). Mykhalovskiy (2001) identifies an important transformation that comes into play with the use of care maps. He argues that the managerial involvement in the Acute Myocardial Infarction

Care Pathway he investigated represented a new way for managers to respond to patients and their health care problems. Responding "evidentially" to clinical problems made it possible for managers to be involved as experts in accountability for clinical decisions, previously the purview of clinically trained professionals only. In this case, the managers were involved in implementing a program that standardized the length of time a patient would stay in a cardiac intensive care following a heart attack.

Re-engineering work processes

"Re-engineering" (Bergman, 1994) produces another way of integrating and streamlining professional activities. Re-engineering is another way of talking about restructuring. Hospital re-engineering is based on the premise that "business processes should be designed around related and interdependent tasks that together produce an outcome that fulfils a defined consumer need" (Kralovec cited in Bergman, 1994, p. 28). In hospitals where re-engineering strategies are being implemented, the strategies are closely aligned to the CMG funding formulas. Many contemporary hospitals now organize their budgets through "strategic business units" organized around specific "products" such as the production of services for high-risk obstetrics (Grinspun, p. 31). In restructured/re-engineered hospitals, traditional departmental professional groupings (pharmacists, nurses, social workers, dieticians, physiotherapists and occupational therapists) and other hospital services (laboratory, housekeeping, radiology, food services and so forth) are dismantled. Administrative lines of communication and managerial authority such as "practice leaders" and "directors" (Vancouver Acute Organizational Chart, May 2003) are grouped according to "programs" (as opposed to professional disciplines). This

approach to hospital restructuring is known as "program management" or "integrated programs". Staff are aligned to home programs (i.e. maternal, child and family health; adult medical care; seniors health and chronic care) which are organized around "logical groupings of health services for consumers with common needs" (NRGH, Integrated health programs, 1998).[14]

Changed administrative configurations merge professional boundaries, creating more generic groups of workers. Program management is expected to produce "marked flexibility" (Miller,1997) with various workers readily taking up a variety of aspects of one another's traditional work processes (Shears, Wyenn, and Kutzleb, 1998; O' Brian, 1998). In the program management literature, new professional "chains of command" produce a professional "mix" of professionals with "expert knowledge in specific program areas" (NRGH,1998, p. 5). Most program management organizational charts include physicians, nurses and a variety of allied health professionals as the "team partners" within each program. In addition, within program management, some hospitals have developed a new category of employee often referred to as a multi-skilled worker (a combination of nursing assistants, housekeepers and unit clerks) (Ellis and Closson, 1994). The goal of this re-engineered staff deployment is said to be the alignment of individual workers' commitments to the managerial priority of increased efficiency. As one proponent states "Program management not only encourages health care providers to develop innovative new approaches to patient care, but also makes them more accountable for resource utilization" (VanDeVelde-Coke, 1999, p. 137). Instructions to managers teach them how to structure the work processes in order to consistently draw

team members' attention to records of their performance, their budget, and their "outputs" (Krueger Wilson and Porter O'Grady, 1995).

Criticism abounds. Critics of these approaches to re-engineering professional services point out that, despite how the language of re-engineered programs promises flexibility among skilled groups of professionals with "expert knowledge", their aim is to enhance efficiency through the elimination of variation among patient treatments and among care providers (Armstrong and Armstrong, 1996, p. 135). Critics predict that in re-engineered work designs professionals' use of time will be closely scrutinized and that any time spent on work that is not considered "value added" such as time used to share information, consult, or to comfort will be considered "idle time" (Armstrong and Armstrong, 1996 p. 135) and will be eliminated. Richardson (1994) argues "the advent of the generic health care workers ushers in an era of lesser-skilled, inadequately trained, inexperienced and less-qualified health care providers" (p. 29). The fact that many of the approaches to re-engineering hospital work processes evolved from "product-line-management" approaches of the manufacturing industry has provoked controversy in relation to the appropriateness of their application in hospitals (Grinspun, 2000, Brannon, 1996).

In Canada, adaptations of managed care approaches have also been introduced under programs of "patient focused" or "patient centred" care, (Grinspun, 2000, Fuller 2001). Ideally, with "pure" patient focused care, the actual physical design of the hospital is changed. Each patient care unit might be equipped with an admitting area, a diagnostic

laboratory, a satellite pharmacy and a rehabilitation room. The expressed intent of patient focused care is to "reduce the number of people and places a patient encounters during a hospital stay" (Dechant, 1999, p. 427). It accomplishes this by "cross-training, a system that increases staff productivity by reducing 'down' time". (Dechant, 1999, p. 428). A cost-oriented approach to hospital redesign, it is intended to "decrease the number of personnel, the amount of waiting time, and the amount of travel time patients experience in the daily processes of care" (Dechant, 1999, p. 428). In keeping with other strategies of managed care, the express purpose of these "point of care" designs are to minimize the amount of resources a patient uses while hospitalized.

Using the literature

The nursing management literature produces a strong endorsement for the direction hospital restructuring has taken. In this literature, "success stories" about the new programs and strategies along with strong support for the new accountability structures paint a picture at odds from that of the nurses whose accounts I gathered. From the standpoint offered in the nursing management literature, one might question the validity of concerns expressed by the nurses of NUC (Chapter One) who were dissatisfied with changes in their work and its management. The success stories in the literature are convincingly argued and supported by compelling data about improvements being accomplished. Nonetheless, despite the strong rhetoric of the management literature, it seems unlikely that the nurses with whom I was acquainted and whom I knew as experienced, competent practitioners, could all be wrong to be so unhappy with the changes in their work. My informants went to some lengths to resist changes of the sort I read about, yet I am unable to dismiss them as people who simply are unable to adapt,

who are inflexible, and who are holding to rigidly old-fashioned ideas. In fact, during my research I observed these nurses struggling to make a success of the new processes, willingly learning the new language of the restructured setting and reformulating what was expected of them and their patients.

The passionate resistance the NUC nurses launched in relation to concerns about their practice did not fit with what I read about patient care "improvements" described in the nursing management literature. My informants from NUC and my own observations of Ms. Shoulder and the care my aunt received during her hospitalization contest the view being put forward in the nursing management literature. Thus, my reading of the health/nursing management literature on hospital restructuring redirects my attention to the contested terrain of competent nursing practice I introduced in Chapter One. My reading about the apparent improvements being accomplished through new funding strategies, regionalization, quality improvement programs, bed utilization strategies, managed care, case management, pathways, care-maps, and re-engineered work processes fails to shed light on the questions my preliminary field work brought into view. Despite my detailed reading I am left wondering exactly *how* nurses do health care reform? What is included and what is left out of nurses' work, both in the actual embodied practise of nursing, and in the methods used to measure and quantify it? It is a critique that is currently missing from most of the nursing and management literature.

From the perspective of some critics of health care reform and hospital restructuring whom I have cited here, I could see how my informants are involved in systems of health

provision that may even work against the interests of the Canadian public. Descriptions of privatization, disputed labour practices, increased home care services and so forth offer explanations into how restructuring produces a system less interested in people than in saving money. Yet, even in this critical discourse, it was not clear to me how my nurse informants' troubles were put together, how, for instance, their sense of professionalism became tied into the new accountability structures such as I observed when the nurses of NUC framed their concerns about the quality assurance forms as: "an issue of nurses feeling disrespected, not supported and not *listened* to. It is an issue of professionalism" (NUC agenda, May 1996).

As in the literature from nursing management, I have found a distinctive perspective on hospital restructuring in nurses' "mainstream" professional literature. This discourse includes a variety of studies exploring the conditions of nurses' work and the new era of nursing care being produced. Many of these studies rely on statistical analyses using data generated through the disciplinary approaches of biostatistics, health services research and clinical epidemiology which have enjoyed growing popularity through the era of health care reform (Mykhalovskiy, 2001, p. 269). In nurses' professional literature, findings from several studies point to problems for nurses and their patients in re-engineered hospitals. These analyses counter the statistical evidence of "improvement" being argued in the managerial discourse. In much of nurses' professional literature evidence is proffered that, in fact, standards of care are being jeopardized. In this body of research nurses' work is investigated through conceptual and categorical forms such as notions of "patient acuity", "patient outcomes", "work roles", "work load", "labour

costs", and "patient occurrences" (Shamian, Kerr, Laschinger, andThomson, 2002; Aiken, Clarke, Sloane et al. 2002; Finlayson and Gower 2002; Ritter-Teitel, 2002; Laschinger, Shamian, andThomson 2001; Clarke, Laschinger, Giovanetti et al. 2001; Norrish and Rundall, 2001; Lichtig, Knauf and Milholland 1999). They use numerically-based data to make comparisons between such things as "staffing levels to patient mortality, emotional exhaustion, burnout and job dissatisfaction" (Clarke et al. 2001, p. 50). The perspective being brought into view through these studies appear to support some of the issues the nurses of NUC were raising. In fact, Clarke et al. (2001) concluded that management strategies to improve hospital workplace environments such as "effective and visible nursing leadership as well as attend(ing) to the human relations aspect of work ...will demonstrate to nurses that they are valued and respected" (pp 54-55) – almost the very same wording for the issue that the NUC nurses placed on their agenda for their meeting with managers ("This is an issue of nurses feeling disrespected, not supported and not listened to" (NUC agenda, May1996). What is missing from this research, (that is captured by my story of Nurse Linda) is *what is actually happening* in the practices of nurses in the face of reform. The survey methods that include questions and analysis of such things as "the revised nursing work index (NWI-R)" and the "Maslach Burnout Inventory (MBI)" (Clarke et al. 2001, p. 52) use research approaches that are similar to the tools being used to both implement and evaluate reform. In the Clarke et al. (2001) study of "the impact of workplace organizational environment on nurse and patient outcomes"(p. 51) the researchers developed survey instruments that identified "criteria" and "subscales" that were "rated on a seven-point scale" and reported

as "descriptive" and "inferential statistics" (Clarke et al. 2001). The researchers found that

> Hospitals that provide adequate resources to enable nurses to provide high quality of care based on their professional standards, allow control over nursing practice, have strong nursing leadership focus and foster effective nurse-physician collaboration are more likely to witness less burnout in nurses and lower turnover intentions among nurses" (p. 54).

Research studies such as these do little to explain the everyday experiences I observed and heard about while conducting my own inquiry. For instance, the apparently routine and insignificant work Linda accomplished with Ms. Shoulder, when she offered her a small cardboard tray in case she vomited and suggested she purchase Gravol on the way home. Nursing acts such as these, and their significance to restructuring, remain invisible within the conventional approaches used examine nurses' work in reformed hospitals. In nurses' professional journals, most research being conducted to evaluate hospital restructuring relies on the same technological approaches that I am suggesting are heavily implicated in the restructuring efforts I have been describing.

There is a small body of research that, using ethnographic methods, informs and supports the explication my own inquiry undertakes. Marie Campbell (1988a, 1990, 1992, 1995, 1998a, 1998b, 2000), and her collaborators (Campbell and Jackson, 1992); (Campbell, Copeland and Tate, 1998) follow the methodological approach of my own study (institutional ethnography) to produce an important chronological/ethnographic "map" of practices organizing nursing. Dating back to the mid 1980's, at the start of the health care reforms, this work explicitly links to and critically informs my own inquiry. Gregor,

Keddy, Foster and Denney (2000) and Gustafson (2000) also use institutional ethnography to explore how new methods of documentation infuse nurses' work with a fiscal imperative and how these practices result in nurses (unwittingly) limiting the delivery of resources to people in need and downloading work onto other, unpaid women outside the formal health care system. Purkis (1999, 2001) uses critical ethnographic methods to explicate how technologies of charting, intended to make nurses' work textually visible, also produce "contingent processes" of domination (1999 p. 147). Varcoe and Rodney (2002) and Rodney, Varcoe and McCormick (in press) use ethnography to explore "invisible nursing work". They write about how nurses' respond to conditions of "scarcity" in troubling ways. Varcoe and Rodeney (2002) identified how nurses "adjust their work to this evolving corporate context and make sense of the changing conditions of their work" (p. 105). McCormick's (1997) ethnography suggests that nurses "create organization" within unconscious practices that reproduce societal practices of oppression. Street, (1992, 1995, 1998) produced an extensive "critical ethnography" designed to "enable nurses to recognize the politics that constrain their clinical practices and to understand the mechanisms that maintain and legitimate oppressive structures for themselves and their patients (1992, p. 276). My own study, like the ethnographic work of this small group, raises critical questions about what actually happens in the practices of nurses. I am interested in building an account of how nurses are active participants in the restructured workplace. My inquiry uses the knowledge of nurses who work in the setting, as a tool, to broaden their analysis of their own everyday life.

My inquiry never loses sight of Nurse Linda, as an active subject, doing the work that she knows how or learns how to do that constitute the "efficiencies", "improvements", "burnout" and "increased acuity" I read about in the literature. The inquiry begins in the embodied sites of nurses' work where policy, people and organizational practices come together. It looks analytically at the social organization of action in actual sites of service provision. My inquiry is methodologically organized to reverse the conventional gaze of researchers, policy-makers and administrators. My research depends on upon staying grounded in the everyday/everynight activities of nurses, the embodied subjects for whom the puzzles exist. Rather than building upon the sorts of research that depend on conceptual and categorical forms as a way to understand nurses' work in hospital reform, the inquiry I undertake here maps an empirical ground through which to "talk back" (Heap, 1995). It is an account that offers possibilities for nurses to "know" about how their embodied, local work is put together. As such, it suggests an empirical ground for resistance.

Chapter Three

Developing the theoretical and methodological frame. Institutional Ethnography

In this chapter I introduce some of the theoretical underpinnings of Dorothy Smith's (1987, 1990a, 1990b, 1999, 2001) approach to sociological inquiry that frame my study. It is from Smith that I have learned to think of my nurse informants as embodied, locally situated actors who are organized to act and produce nursing in a world that I can observe and analyze. Institutional ethnography (IE) is the "alternative sociology" Smith developed to allow inquiry into what actually happens from the standpoint of actual people.

Smith's method has its roots both in Marxism and feminism. Her experiences of teaching sociology in a male dominated discipline, provided the original "data" Smith used to develop her *sociology for women* that has developed into a *sociology for people* (Campbell and Gregor, 2003, p. 3). Within her everyday life, Smith recognized that her "embodied" knowledge and experience – the work she undertook in her busy domestic life – stood in sharp contrast to the theoretical sociology she and her (predominantly male) colleagues had been trained to do and teach. The knowledgeable activities she carried out as a homemaker for her young family constituted an entire realm of the social world that her male colleagues not only took-for-granted, but also discounted, as a legitimate basis for knowing (Smith 1987). Smith argued that the work that women accomplished allowed men to live in a privileged "head-world". It was a world in which the everyday activities of domestic life could be completely overlooked and effectively

discounted, "hidden", by the dominating activities of the authorizing academy (Smith, 1999). Orthodox sociology was a discipline filled with the ideas and relevances of men. Smith's analysis of the systematic subordination of the contributions and conditions of women's work led her to her sociological approach, the social organization of knowledge, which insisted that "knowing" the social must come from a firm grounding "inside" the materiality of everyday life. Institutional ethnography is the methodology that applies that approach. In this chapter I outline how I took up IE's terms and tenets to guide my inquiry into nursing practices in contemporary hospitals.

Standpoint and disjuncture

Standpoint is a term used by an institutional ethnographer to "explicitly note the place from which she looks, acknowledging the way that her inquiry is 'situated' vis-à-vis other knowers and other ways of knowing" (Campbell and Manicom, 1995, p. 7). Standpoint "helps the researcher identify 'whose side she is on' while constructing an account that can be trusted" (ibid, p. 7). Taking the standpoint of nurses in direct practice engrains into my inquiry the particular relevancies of nurses (countering other more dominant relevancies).

The standpoint of actual nurses kept me grounded in what is relevant to them as I puzzled over the disparity between what nurses were saying about their practice and how that same practice was represented in the nursing review document, and indeed, in nurses' own professional literature. I actively used the standpoint of these nurses, what they know about, to situate me vis-à-vis my reading of the authoritative accounts about "evidence-based improvements" or nurses' "burnout". I used the standpoint of nurses to

unveil the "disjuncture" (Smith, 1987) at the line of fault where "good nursing practice" is contested.

When Smith (1987) uses the term "disjuncture" she is referring to the preponderant trend within sociology (and indeed a trend in many aspects of social and scientific life) to construct abstract *accounts* of experience, that categorize and use descriptive language to reference the concrete realities of everyday life. Stories about events employ different language when told by participants than they do when told by sociologists. Different elements may be emphasized. One's standpoint will be reflected in what is noticed, recorded and described. As I noted in my review of the literature, even critical researchers start in a theorized world that employs "nominalized social phenomena" (Smith, 1999 p. 107-8) (such as "patient acuity", "workload", "patient occurrences", "privatization" and so forth) that shifts the perspective away from that of actual people. Throughout my inquiry, I use Smith's emphasis on standpoint to ground my research in things actually happening for nurses, in their embodied experiences and activities.

Social relations

I use standpoint as a methodological tool to provide the place from which I can look (out) and to direct me to the social context of hospital nurses' experience. Using the activities of the nurse informants, such as Linda's work with Ms. Shoulder, I use Smith's methodological tools to trace the organization of their experiences. For instance, I followed and began to specify the institutional organizing that accounted for how Linda's morning's work unfolded. To do this, I focus analytical attention on the social relations of nurses' work sites. Smith's use of the term *social relations* provides the way I

understand the coordinated, interconnected interdependence of human activity. "Social relations" is a concept, but its use leads to discovery of material features of daily courses of action that institutional ethnographers will observe and use in the course of an inquiry. For Smith (1990a), social relations are to be seen as a:

> process of actual activities in a temporal sequence. Its different moments are dependent upon one another and articulated to one another not functionally but as sequences in which the forgoing intends the subsequent and in which the subsequent "realizes" or accomplishes the social character of the preceding (p. 319).

Social relations, understood in this temporal way, are comprised of extended points of activity (people's work) that interweave the actions of innumerable people, working in local and distant places. Using Dorothy Smith's view of social relations I examine health care reform as nothing more, and nothing less, than the extensive coordination of people's purposeful activities across multiple local sites of action. The social relations of health care reform and hospital restructuring produce an empirical ground for my analysis of how contemporary nursing work is organized.

Work

Smith's definition of work is, as she puts it, "generous" (Smith, 1987). Her notion of work includes practical decision-making and all the ways "people are actually involved in the production of their everyday world" (Smith, 1987, p. 166). Nurses' work, viewed within Smith's generous definition, encompasses all of the activities engaged in by nurses (and many others) that constitute and become the restructured work site. Nurses' work includes many more activities than those that are generally recognized and recorded as "nursing". It includes learning how to enact restructuring competently within a nurse's sense of professionalism. Even though it may include activities that are illicit; it includes

all the work that makes it possible for "nursing' to get done. One example is the stashing of, and searching for, bed linens that I observed when I was working beside a nurse who checked numerous "hidden' locations to find a pillow-slip for her patient whose pillow had been soiled with vomit. Using the IE definition of work I include the work that goes into organizing the "paperwork" that nurses are required to complete, the forms and requisitions they circulate. All such activities are considered part of the work, the temporal flow of nurses' activities that are constitutive of the social relations organizing nurses' practice in particular and, frequently, repetitive ways. To understand nurses' work, analysts need to be able to "see" nurses' work activities and also to see how official accounts of it differ from what actually happens.

Smith's thinking about work alerts analysts to pay attention to what is required to "get things done" in order to identify the work that is often subsumed and invisible within official descriptions. Nurses' work – the activities of the NUC activists, the activities of Nurse Linda with Ms. Shoulder, and the activities of the nurses who took care of my hospitalized aunt – included both work that was counted and work that was not counted. Enacted in a moment in time by individuals, these nurses did what had to get done. The world of bodies had to be articulated to official knowledge, institutions and procedures. Nurses do the embodied work that makes such connections. Accomplishing Ms. Shoulder's discharge relied on Linda to "make do" so that the transition out of hospital would happen as necessary at the appointed time.

Ruling relations

Smith's (1987) thinking about ruling originates with Marx (eg. Marx and Engels, 1970). Like Marx, Smith is interested in class, and like Marx, Smith views class not as abstracted ideas of power and oppression, but as "a fundamental organization of the relations in which peoples' lives are caught up" (1987, p. 223). For Smith, as for Marx class and ruling relations are produced by people – "while we work and struggle, our everyday acts and intentions are locked into the underlying dynamic of the relations and forces of production and governed by the powers they give rise to" (1987, p.135). But Smith departs from Marx's analysis, updating it. In the twenty-first century, class and class interests are governed through different practices than those of the earlier capitalist era. Smith (1990b) maintains that in contemporary society ruling is organized through a construction of knowledge that relies on complex forms of reporting, accounting, noting and recording *particular aspects* of people's work and lives. These reporting and accounting activities produce a particular framing of issues and concerns, which then organize, influence and rule what happens. Ruling relations are "those forms that we know as bureaucracy, administration, management, professional organization and the media. They include also the complex of discourses, scientific, technical, and cultural that intersect interpenetrate, and coordinate the multiple sites of ruling" (Smith 1990b, p. 6).

Nurses working in contemporary hospitals are producing their nursing work at the intersection of professional, administrative and bureaucratic activities that organize and control nurses' knowledgeable construction of their practice. My inquiry explores and

attempts to answer questions about how nurses' lives are organized and managed outside of their own knowledge and control. The managerial world of hospitals is the organizational context in which much nursing work takes place. I have collected data on the interaction of nurses with new forms of hospital organization.

Linda's and my activities discharging Ms. Shoulder provide an example about how nurses participate in a work organization (the efficiencies of hospital restructuring), the origin of which they know very little. My nurse informants like those discussed by Campbell (1988b, 1992, 1995, 2000) are, in various ways, silenced and deprived of the authority to speak their own knowledge by authoritative forms of bureaucracy, administration, management, and professional organization. Smith's method of inquiry examines how ruling takes place in such everyday practices. These modes of knowing about nurses' work produce official accounts about what is happening that override what nurses themselves have to say. These are the ruling relations I proceed to investigate; to explicate how nurses' work articulates the everyday world of hospital wards and patients lives to professional and bureaucratic demands of health care reform and hospital restructuring.

Texts and organizations

My interest in identifying how strategies of health care reform and hospital restructuring coordinate nurses' practical action in hospitals is situated in the intellectual space Smith (2001) carves out in *Texts and the Ontology of Organizations and Institutions.* In this paper Smith uses her theorizing about texts to examine "how institutions and the phenomena called large-scale organization exist" (p. 159). They exist (and this is

particularly useful for doing institutional ethnography) in the actions of people who bring them into being, not in the theoretical constructs about size, technology and so on. Texts and their centrality to mediating action are, according to Smith, constitutive of organization.

Texts, are defined by Smith as "definite forms of works, numbers, or images that exist in a materially replicable form" (2001, p. 164). People's "activation" (Smith, 2001) of texts carry forward and is part of many of the social relations that interrelate and accomplish the social world in which we act. Smith defines texts broadly, including any reproducible written or imaged material. Paper texts have been the most widely used and distributed form of textual social relations. Computers and other forms of media technology now contribute to the plethora of textual media intersecting with our daily activities. Policy documents, legislative texts, text-books, photographs, newspaper accounts, advertising texts, bureaucratic forms, even musical scores have been investigated using Smith's particular approach to textual analysis. (See Smith and Dobson 2001 including contributions by Smith, Dobson, Pence, Campbell, Rankin, Mykhalovskiy, Turner and Warren. See also Smith, G., 1995; Ng,1995; Bannerrji, 1995; and McCoy, 1995). The ubiquitous presence and diverse forms of texts that contribute to processes of nursing activity create an unlimited resource for exploring nurses' social world.

Using textual analysis I explore how nurses activate specific texts and thus, are brought into coordinated relations with others. Interacting with a text engages readers in a "text-reader conversation" (Smith,1999, 2001) in which one side of the conversation is

established by the text. Take for example my description, in Chapter One, of my aunt and I filling out the patient satisfaction survey. It is possible to visualize us as we interacted with the form. We attempted to work with the text bringing our experiences in line with it. We puzzled over "do they mean....?", and we questioned one another, "did they tell you any of this when you got there?" Although we were also conversing with one another, the form the questions took, and their syntax, dominated our documented comments and responses. Despite our best efforts, the text "fixed" what we could say about our experiences. The text inserted its own interests in "admission and orientation", "communication and relationships" and "daily care", which may or may not be what we were interested in reporting.

Taking up Smith's methods, I view and use texts, and their activation by people, as critical features of the social relations organizing work in contemporary hospitals. I investigate the organizational texts that permeate hospitals. Smith's ontology of organizations guides my own thinking about health care reform and hospital restructuring to explicate how textual strategies of reform and restructuring coordinate nurses' hands-on work with patients (work that is generally seen to be professionally self regulated).

My analytic use of texts to explore the social organization of nurses' knowledge is not limited to the use of bureaucratic forms and hospital texts but also engages with the text-reader discourse conversations that occur within the large-scale conversation of nurses' professional publications. I investigate how nurses' discourse, nurses' language use, and the professional regulation of nursing are implicated in the reform and restructuring of

health care that is being carried out. I follow Smith (1999), who makes use of Michel Foucault's (1970) conception of discourse, and his notion of discourse as a regime of disciplinary power. Smith too, identifies the discursive practices of contemporary society as important elements of the ruling relations governing individuals. In Smith's thinking about discourse however, she never loses sight the field of social relations in which a discourse is activated. She considers "discourse" – the scholarly intertextual repartee and the multiple text-reader conversations that the discourse generates – as investigable *activities* that contribute to the material *complex of relations* that organize and coordinate people's lives. Smith's notion of discourse maintains an interest in the presence of subjects who activate the text, in language, in the local moments of writing, reading and understanding. Thus, for Smith, and in my own inquiry, language and discourse is understood to be generated within dialogical social processes (within ruling relations) that, having a material world, can be tracked from the activities of people, into the institution, and back again.

Ideology and ideological practices

Nurses work with bodies but that work is accomplished in contexts that, increasingly, have become known and managed abstractly. Nurses have learned how to treat abstracted categories about patients such as "critical", "unstable", and "long-term-care" or abstracted categories about work processes, such as "workload index", "bed census", "bed utilization" "standards of practice" and so on, as *permanent features* of nursing work and knowledge. With my theorized approach to analysing my data, I know that I must learn what these terms mean in nurses' working life, in actual activities. I must discover how nurses "work" them into care with patients, into their thinking and their

own way of "knowing" about what to do, what must be done first, what must be left out or done differently. Smith (1990a, 1990b) uses the term "ideological practices" to talk about this phenomenon of abstract categorization that infiltrates people's activities across many sites of contemporary work. Ideological categories embedded in contemporary work processes subordinate what can be known about the actual happenings.

Campbell, (1995) provides a detailed description about how nurses learn to use abstract thinking. She describes a process through which student nurses are taught to "see pieces of their everyday activities as instances of concepts on their evaluation forms, when they learn to abstract out of practical work experience those events which 'fit' the conceptual framework that has been provided" (p. 229). She describes how nursing students are taught to look at complex (frequently disordered, and contingent) events of daily practice through the mediating lens of a particular conceptual frame. When this happens, students' attention is directed to "certain elements of patient care and features of the patients themselves that provide the correct data" for, in this case, evaluating their learning (p. 231). The care-maps/critical pathways described in Chapter Two are an example of a managerial attempt to insert elements of efficiency into nurses' thinking and acting. Windle (1994) identified how patient "variances" on the post-anaesthetic recovery care-maps are categorized according to "delays". When nurses start to routinely think about, and document patient "variances" in terms of "delays", other ways that patients may vary could drop out of sight. If this managerial effort is successful, "delays" will become the dominant conceptual category which arises and is expressed. Variances,

as delays, will become a taken-for-granted and ideological way of thinking about, talking about, and practicing nursing.

Ideological codes

Smith (1999) further develops her analytical use of ideology in a discussion about "ideological codes". Ideological codes produce a widely distributed ordering and organization of taken-for-granted practices across diverse discursive sites. I use Smith's (1995) theorizing about ideological codes to focus my interrogation on the text-mediated intersections of business management, health management and professional nursing discourses. Using the analogy of a genetic code Smith describes how ideological codes behave like DNA molecules, replicating and reproducing the ordering of the original molecular structure in successive generations of cells. Like a genetic code, an ideological code is capable of "generating the same order in widely different settings" (p. 159). Smith demonstrates how ideological codes produce a form of social control, providing an interpretive schema of assumptions and taken for granted norms. Ideological codes hook people into the generalizing schema, and produce many of our contemporary ruling practices. For Smith (1999) "The Standard North American Family" (SNAF) is an example of an ideological code prominent in everyday discourse (a male and female adult sharing a household; the adult male providing the primary economic support; the adult female taking primary responsibility for care of husband and children etc.). She discovered that the ideological code (SNAF) referenced her own experience of "single mother", constructing that experience as "deviant". The ideological code produces an Archimedean point of reference; even those who challenge it are positioned by its hegemonic properties and must operate on its terms, hence reproducing it. Smith does

not conceive of an ideological code, such as SNAF as a "formula or a determinate concept" rather she describes an ideological code as:

> A constant generator of *procedures for selecting syntax, categories, and vocabulary in the writing of texts and the production of talk and for interpreting sentences*, written or spoken, ordered by it. (p. 159, original italics).

Smith formulates ideological codes as features of contemporary society that ubiquitously produce a "ruling" interpretive schema across divergent sites of text-mediated public and professional discourse.

For the purpose of my inquiry into nurses' work, I use Smith's theorizing about ideological codes to bring analytical attention to the ideological practices of "deficit reduction/efficiency", as they are manifest across wide discursive sites. "Deficit reduction" is part of a popular "story", a fundamental unit of information, circulating in contemporary Canadian culture and being activated across many sites of practice.

The ideological code is seeded and replicated by strong lobby efforts from right wing "think tanks" such as the business funded C.D. Howe Institute, the Fraser Institute and the Hudson Institute. These institutes, financially supported by business and corporate donations, often identified in the press as non-partisan, have a formidable foothold in the public discourse on the Canadian economy. Through frequent press releases and a prolific list of publications the Canadian business elite have promulgated the theory that the Canadian national economy *must* solve the problems created by state indebtedness. Publications such as that of the C.D. Howe Institute's: *Limits to Care: Reforming*

Canada's Health System in an Age of Restraint (Blomqvist and Brown 1994), promote the "common-sense" theory that Canadians need to "live within their means"; we can no longer afford our apparently extravagant health and social spending.

The economic reform that is being carried out across the globe, by governments of all political persuasions, is presided over by the World Trade Organization, the International Monetary Fund and the World Bank. It is a constituent of the globalization of production, distribution and financial exchange. Aligned with the global relations of capitalism, state policies are being reformed through tax reductions, reductions in public services and increased private ownership. Capital accumulation is bolstered by the expansion of market relations within a previously publicly held infrastructure. (Teeple, 2000, McCoy, 1999; Dominelli and Hoogvelt 1996).

Despite a growing wave of social activism against the institutionalization of globalized trade and its social consequences (CAW, 2003), the ideological code of deficit reduction is a widespread conception about how a history of irresponsible, wasteful government spending has produced a national debt of alarming proportions, which is threatening the viability of Canada's financial and economic system. According to this Canadian lore, circulating since the early 1990's in many intersecting sites of discourse (popular media, government statistics, social science, economics, business, etc.), Canada is currently an "over-taxed" nation. Canadian people are tired of supporting bureaucratic inefficiencies; sacrifices must be made in the interests of sound fiscal government. The policies and practices of health care reform and hospital restructuring are seeded and replicated by the

ideological practices of this broad ideological code that circulates ideas about how Canadians must reconsider their national priorities in order to solve the problems created by state indebtedness – that the sustainability of the publicly insured health system will be jeopardized unless we consider sweeping changes to how health care is delivered. Throughout this dissertation I explicate how nurses' practices are, as Smith would describe, "infected through and through" (Smith, 1999, p. 170) by assumptions about costs and efficiencies that provide a generalizing procedure for "professional" interpretation and action.

Chapter three conclusion

In this chapter I have formulated the analytic framework of my inquiry outlining some of the methodological tenets and tools of institutional ethnography. I have emphasized how my research approach situates nurses' work within a broad matrix of social relations, inside the political economy of contemporary capitalism.

Over the past 20 years governments from across the political spectrum have promoted massive reforms in social programs to achieve overall reduction in social spending. Despite compelling rebuttal from dissenters (Carniol, 1995, 2000; Laxer, 1996; Workman, 1996; Osberg and Fortin, 1996; Teeple, 2000; McQuaig, 1995; Finn, 1985 Tomlinson,1981), pressures from the Bank of Canada, the International Monetary fund, the World Bank and international trade agreements have dominated and cost constraints have prevailed (McQuaig, 1995, Teeple,, 2000). It is within this context that the Canadian health system is being reformed and hospitals are being restructured.

Institutional ethnography guides my study into the social organization of contemporary nursing as it has unfolded within the fiscally driven social reforms of the past two decades. IE offers a theoretical way to analyze nursing practice through concepts of standpoint, social organization, social relations, ruling relations and ideological codes and practices. It provides a method for discovering and analyzing institutional relations of power that are embedded in the written materials and organizational practices of an everyday nursing practice.

In the literature, discussed in the previous chapter, I discovered a contested terrain of "knowing" about what is happening in Canadian hospitals. My analytic stance, in relation to the literature is to view it as *part of* the socially organized world of nursing, where I view it as "data", that contributes in important ways to the problems and puzzles that are the focus of this inquiry. I am left wondering how nurses are brought into the reform agenda in the course of their daily work? What part do nurses play in restructuring hospitals? How does nurses' involvement (as actors) in new managerial technologies affect them and their care giving? How does it affect patients? To find answers to these and related questions, I explore what actually happens to some actual nurses, beginning with my observations of nurses at work and my recording of nurses' talk about their work. I explicate how strategies for hospital restructuring are played out, in the kind of experiences that my data records.

Chapter Four

Constituting health care knowledge in managerial form.

Introduction

Hospitals are restructured through the implementation of systematized administrative programs. In this chapter I examine some of these programs, especially those I call knowledge-based. Knowledge to make decisions in the business-oriented efficient manner outlined in the hospital management literature relies on systems of collecting, counting, aggregating and comparing "facts". Here I explicate three administrative systems found in restructured hospitals that align clinical work with a new emphasis on costs that has become of pervasive managerial relevance. To start, I explicate the technology of a hospital's admission/discharge and transfer system (ADT), showing how it produces technological solutions for managing the scarce resource of hospital space (beds). I move next to detail an initiative of the Canadian Institute of Health Information (CIHI) [15] known as the Alternate Level of Care (ALC) designation. I explicate how ALC classifies and categorizes patients in an attempt to achieve cost reductions through managing both bed utilization and nursing labour. Finally, in this chapter I discuss accountability strategies. I show how information technologies are used at the "end-stage" of managed health care activities where objectified knowledge about cost-efficiency is joined with objectified knowledge about quality of patient care that is constructed into a managerial form. To do this I return to the patient satisfaction survey my aunt and I completed. I show how, in a managed health care workplace, when large-scale systems for cost efficiencies are in place, managers are positioned to assess and

manage the competence of both professional and non-professional activities and to verify "effectiveness". Constituting patient satisfaction, in text, as an objective, unitary state helps provide the definitive knowledge of accountability that can be activated as administrative solutions to new problems arising in restructured hospitals.

In each case, whether it is to manage resources efficiently or to apply them effectively, a method is required to represent what is happening in a new form that is amenable to knowledge-based managerial action and control. Each system I discuss in this chapter constitutes the "reality" of a managerial interest in textual form that I will argue, following Smith (1990, 1999) is a hyper reality. [16] My purpose in this chapter is to explicate the health information technologies that build the managerial (cost-oriented and abstract) knowledge, the authoritative account of (the hyper reality) what is going on in hospitals upon which patient care decisions are made and various kinds of control are exercised.

Admission, Discharge and Transfer: Three patients in one bed

My ethnographic data offers an instance of how the admission/discharge/transfer system (the ADT) is very much implicated, both in the actual work of nurses (such as Nurse Linda with Ms. Shoulder), and in the subsequent work of managers who organize program efficiencies. I show how the ADT system supports administrative (cost cutting) decisions about clinical aspects of patient care that do not necessarily fit with nurses' knowledge and judgement. At the time I observed Nurse Linda's "everyday" nursing practice, the allocated length of stay[17] for a patient undergoing a shoulder repair was one night. In 2003, patients undergoing shoulder repairs are treated as "day-care"

(ambulatory care), and are discharged home on the same day of their surgery. Nurse Linda's ad hoc activities that produced Ms. Shoulder's 1100 discharge (the antacid, the advice about over the counter anti-nausea drugs, the vomit container to take in the car), examined alongside an administrative decision to categorize the needs and care of patients undergoing shoulder repair as "same day" surgeries, provide a particularly compelling illustration of how administrative use of objective health information is used to make business-oriented decisions that organize nursing care. My inquiry explicates how the managerial technology affects nurses and nursing.

My inquiry begins in the activities of Nurse Linda, Ms. Shoulder and Ms. Leg Wound. Ms. Shoulder and Ms. Leg Wound did not just appear in Nurse Linda's work purview. There is a whole system of texts and people's activity that organizes the arrival of Ms. Leg Wound in relation to the predicted discharge of Ms. Shoulder. An endemic problem in hospitals has been the essential unpredictability of patients' arrival and departure times. In an effort to optimize resources, systems have been put into place that attempt to predict and pre-arrange (as much as is possible) the movement of patients through hospital beds. This is accomplished with the help of the ADT system. The ADT system is a critical institutional feature of how patients and hospital resources are categorized and organized. A computerized software program, it assists admitting clerks and bed utilization clerks to locate empty beds throughout the hospital. It is relied upon to produce an apparently orderly and timely movement of patients in and out of beds throughout the surgical operating room, emergency room, admitting department, wards and nursing specialty units.

The ADT system is a tool also used to monitor and ration the use of hospital beds. It provides a means to manage local pressures of bed scarcity, (for Linda and her patients as she juggled the needs of two patients vying for the limited resource of a single bed). In the context of scarcity of hospital space, the ADT system provides a system of matching hospital space (resources) to a list of prospective patients waiting for beds. It contributes to a screening and monitoring process to ensure that patients are assigned to the "right" beds and it enables clerks to track which beds have been cleared. [18]

The ADT software produces administrative knowledge through an ongoing recording structure of categorizing and counting. It generates important information about "hospital activity". ADT-generated information is central to the use of hospital space, a costly resource that hospital managers are required to manage efficiently. The ADT system tracks patients occupying beds to produce information which local hospital administrators and more distant regional and provincial officials use to make informed (knowledge-based) decisions. Hospitals make use of ADT information to demonstrate their control of costs.

The (2000) decision to designate shoulder surgeries as "same-day" procedures, thus shortening the time these patients spend in the hospital, did not arise spontaneously. It is a knowledge-based decision. A patient services director I interviewed reflected on how the "same-day" designation was made. Initially, the director described a provincial trend to treat shoulder surgeries as "day-care". This knowledge was available to this director in the form of statistics, amassed through the ADT systems of several "peer" hospitals

across British Columbia. Hospitals send accumulated ADT data to the ministry of health in the form of monthly statistics. This data is collated into "peer hospital" groups and this information is distributed back to the hospitals. The data produces an aggregated knowledge base about bed utilization across the province. Prompted by the knowledge about the provincial trend, the manager I interviewed, and her management colleagues, initiated an examination of their own hospital practices.

During the interview with the patient services manager, she discussed some of the issues she faced when reassigning shoulder repairs into the ambulatory care program. The manager explained how "when shoulders were first being considered for ambulatory care nurses expressed many worries about patient's pain management during that first night at home". She then added, "however we knew it could be done, that it was working in other centres; patients at home do well". What this nursing manager "knew" and what her information supported was that patients undergoing shoulder surgeries "do well" at home when, as part of the ambulatory care program, they are discharged on the same day of the surgery. The manager's knowledge about how well patients fare following a shoulder repair seemed at odds with my experience of discharging a decidedly unwell woman with an emesis basin the morning after a shoulder surgery. It also seemed at odds with other nurses I spoke to about shoulder surgeries who explained that, in their experience, the anaesthetic block used to perform the surgery works better in some patients than in others. They noted how some patients experience a great deal of pain and require substantial nursing support, while others do not.

The managerial knowledge about shoulder surgeries is based on statistical evaluation. For the manager, "doing well" is most likely based on data oriented to statistical "outcomes". Knowledge about outcomes is developed through health service research that examines quantifiable measurements such as the number of clinic visits post-operatively, the time it takes for patients to regain range of movement, the readmission rates of patients who are discharged home on the same day, or through comparing Length of Stay (LOS) to rates of readmission across hospitals. Health services research is used as a resource by hospital managers. Statistical evidence is used to "review . . . length of stay data against the performance of comparable institutions" (Chen and Naylor (1993) cited in Mykhalovskiy (2001), p. 275). This sort of criteria is different from the criteria of the nurses who I spoke to who were worried about "how well" patients would do at home following shoulder surgery. For nurses, the experience of pain and suffering counts. However, the sorts of concerns nurses have do not get included in the official data that is gathered to make a decision about how shoulder surgeries are to be accommodated. During an interview with a patient services director, she commented on an initiative she was involved in to make laparoscopic gall bladder surgery an "ambulatory" procedure. She said:

> I personally am a little reluctant because I think it's a major surgery and I think they can benefit from an overnight stay. However, if I take on that role, that is the nurse coming out in me.

The Patient Care Director understood that "the nurse in her" was not referring to an authoritative knowledge and that her job required her to override these sorts of "nursing" concerns. She continued:

> We find that nurses do advocate strongly for patients. First of all we have our doctors not wanting to send the patients home, then we have our nurses who can often find reasons why the patients need to stay, frankly some reasonable and some unreasonable, but that they do tend to be protective.

Such idiosyncrasies among doctors and nurses are something to be managed. Authoritative statistical knowledge provides the means through which standards can be developed that are used to control variations both among patients themselves (the varied success of the anaesthetic block) and professionals ("some reasonable and some unreasonable"). The (nurse) manager concluded by saying:

> And I have many years of practice. I am astounded at the changes. It is surprising to me. I have been here for a lot of changes and have been involved in the implementation of change – the pre-admit, and same day admit procedures where people may have stayed for a month and now they going home the day of. I am constantly amazed at people's ability, on the whole, to take that on.

Despite some doubts, this manager is confident in her management responsibility to ensure that patients are not held in the hospital just because nurses or doctors have "found reasons" to extend their stay. Her role demands that she have a way to monitor the "reasonableness" of the professional judgements being expressed.

In the case of shoulder surgeries, a standard was being imposed on all patients that did not allow for the sorts of variations among patients that nurses' worry about. Statistical comparisons such as those being used to justify the change in shoulder surgeries were used to validate how, in fact, patients at home "do well". The administrative review of the ADT data from other hospitals resulted in an initiative, despite nurses' qualms, to assign shoulder surgery patients to the ambulatory care program. This administrative knowledge "trumps" local judgement by professional caregivers.

The ADT system: How it works

The ADT system contributes to the textual, (numerically-based) monitoring of cost-relevant inefficiencies that prompts managers to review clinical practices. At this hospital, the ADT system is run from the top floor of the hospital physically removed from the busily peopled settings of the hospital units. A bed utilization clerk, whose work is authorized by patient service managers in concert with clerks in the hospital admitting department and the OR booking office, organizes patient arrivals into ward beds. The clerk's work with the ADT system determines Ms. Leg Wound arrival on Ward Bones. It organizes which bed she will be assigned to and who might be "moved" in order to accommodate her (should Nurse Linda not accomplish Ms. Shoulder's discharge, for instance). The ADT system tracks and locates patients as they are admitted into, discharged from, and transferred among beds.

Assigning patients to beds is not a simple undertaking. Beds are in chronic short supply in relation to the number of patients who are waiting for them. As well, patients cannot be randomly placed into any available bed. Patients are assigned to beds based on the nature of their illness, their sex, and whether or not they have requested a private room and can be considered "revenue generating". The bed utilization clerk uses computer generated "bed maps" to locate patients and beds. The clerk uses accepted, established protocols to textually assign new patients to beds. The bed utilization clerk explained some of the manoeuvres possible in the textual "hyper reality" of the computer software that generates the ADT system's bed maps:

> We admit people but we (may) have no beds for them. They come in before the bed is ready for them. So, in the system we create this place called SDA's (Same Day Admits). They are fictional rooms.

Ms Leg Wound is admitted to the hospital, and indeed undergoes her surgery, before there is any confirmation that there will be a bed (or a nurse) available for her recovery. In the ADT system, the problem of keeping the queued patients in view is solved by the creation of a textual "space" in which to house them. The physical work of finding (real) beds is organized by this computer technology. Efficient bed utilization is demonstrated through a textual construction in which "fictitious" beds apparently expand the hospital's capacity. I heard this talked about by a hospital executive director who was questioning the wisdom of "110% utilization" and by Nurse Linda when she referred to her experience of having "three patients to a bed". The constant overlap of patients shapes the "speeded up" work processes of nurses who are always irremediably grounded in the embodied actualities of their daily/nightly work. (This accounts for Nurse Linda taking "short-cuts" when treating Ms. Shoulder's nausea and hurrying her out of the hospital).

As the bed utilization clerk enters information about patients into the computerized ADT program to create bed maps and assign beds, she begins the generation of a great deal of statistical information. The number of patients "in" and "out" of each inpatient area in the hospital is counted. A bed utilization clerk I interviewed gave me copies of the monthly reports generated through the ADT system that she circulates to the patient service directors at her hospital. The monthly reports (Appendix B), known as "inpatient location statistics", are organized into headings – "bed days" "patient days" "average length of stay" "average daily and monthly census", and "percentage of occupancy". Yet

other data, generated through the ADT system, are known as "service statistics". These data rely on complex categorization systems for admitted patients. Accumulated "patient days" are broken down into various categories and sub-categories. There are:1) "service" categories: (e.g. medicine/general practice; surgery/ear nose and throat; medicine/neurology); 2) "payment" categories: (e.g. Long-term care/billable) and 3) categories of "appropriateness": (e.g. alternate level of care [19]). Information generated through the ADT system is aligned with (and produces) information related to case mix groups (discussed in Chapter Two). ADT data is used by hospital administrators and ministry bureaucrats to measure "resource intensity" and to compare resource utilization that becomes part of funding decisions.

Through this system of data collection, physicians' practices can be compared one to the next, elements of nursing units can be compared, and hospital's costs and use of resources can be compared to that of other hospitals. One nursing team leader I interviewed discussed how an "older" surgeon tended to "hang onto his patients too long" and how this became a problem for her to resolve. She explained how ADT generated data was useful to her to broach this topic with the offending doctor. She was able to show him how his cases stayed in the hospital longer, on average, than those of his orthopedic colleagues, how his practices reflected a wasteful use of the valuable bed resources.[20]

ADT data is used to make decisions about bed utilization: Local knowledge for hospital operations

The ADT system builds apparently "factual accounts", Smith's (1990, 1999) text-mediated hyper reality, about patients' movements through the hospital in relation to the reality of fixed space. In the textual hyper reality the ADT system creates, it makes sense to invent fictitious beds where patients can be placed (and be counted) in order to demonstrate 110% bed utilization. The ADT hyppereality reduces the possibility that any hospital bed is left vacant. However, my accounts in Chapter One indicate that the fictitious beds of the ADT system create challenges to be overcome, for nurses, who must work "on the ground" with actual beds and actual patients to accomplish the efficiencies of the rapid turnover of the hospital's high-speed "production line". While the ADT system appears to be a neutral way of keeping track of where patients are in the hospital, my analysis reveals it to be more than that. As the crucial tool used to produce knowledge for managing "bed capacity" it intervenes in nurses' work and patient care. It generates authorized, "objective" knowledge that supports standard procedures. It is used to subordinate nurses' (knowledgeable) worries about patients' pain and suffering that are variable and subjective.

Beyond the ADT based decision to expand the day care surgery program to accommodate shoulder surgeries, during my research at that same hospital, I observed another occasion when ADT generated knowledge resulted in a managerial initiative to increase efficiencies in bed capacity. In January 2002 an administrative decision was made to relax rules about same-sex accommodations. All rooms would now be considered "unisex". This decision reflects an attempt to reduce wasted resources during

complicated and labour intensive in-patient transfers that, according to ADT data, were showing a steady rise. The unisex initiative had a significant impact on the ability to improve bed utilization while at the same time reducing the use of (expensive) nursing labour used to move people about.

During an interview with a bed utilization clerk, prior to the new unisex policy, she described the challenges of maintaining sex segregation. She explained the complex task she encountered daily, as the informal 4:00 p.m. "cut-off time" approached, when further discharges are unlikely and she can reasonably predict that all the patients in the hospital will be staying the night. She has effectively "run out" of appropriately sexed beds. It no longer works to create fictitious beds because patients are physically bottlenecked in various holding areas of the hospital. Transferring patients among rooms is one way to "find beds". The clerk gave an example of this work as she explained:

> I mean some of our moves are just awful. We have some really bad moves. If we have two four-bed male rooms and each one has an empty bed in it. But we need three female beds. So you have two empty male beds but no empty female beds. So then you empty a semi-private room, move two of the guys from the four-bed rooms into the semi, then you move the third guy from the four-bed room into the fourth bed in the other male room, and now you have four empty beds you can put ladies in. I mean they can even get more complicated than that but I can't think of a good example right now...sometimes you're moving people all over the place just to get the right combination of same sex beds.

Transferring patients from one bed to another is a technique that is used to "juggle" and "squeeze" patients in, in order to maximize the bed resources within sex segregated restrictions. For the bed utilization clerk the work of transferring patients to find beds is a complex computer puzzle. Through maneuvering patients on her bed maps, she is able

to make highly pressured decisions about where patients are to be placed in the hospital. In this explanation about "awful moves", the embodied work of nurses in direct care is also recognizable – nurses pushing the beds, gathering belongings from bedside lockers, informing the receiving nurses about the condition and needs of the patients being moved, gathering and moving the appropriate records, medications, equipment and so forth.

Using the cumulative ADT generated statistics of "awful moves" administrators, too, can "see" the labour involved in transferring patients. For the administrators though, their interests are in costs and efficiencies. Transferring admitted patients from bed to bed is also costly. When patients are moved from one bed to another it involves not only the bed utilization clerks and nurses, but also ward clerks, housekeeping staff, medical records personnel, dietary clerks and so forth who must adjust their records and processes to accommodate patient transfers. For this reason, the bed utilization clerk explained, patients who are in four bed wards or semi-private rooms are seldom moved to accommodate mere preferences (for instance a preference to be placed by the window or nearer the bathroom). Transferring a patient from one bed to another is, most often, reserved as a tactic to "find beds" (or to accommodate a "revenue generating" patient who has requested a private room and can be categorized as a "paying private").[21] Transfers are carefully monitored. According to the bed utilization clerk I interviewed, the ADT system showed a continual increase in the number of patient transfers – the "awful moves". Hence, managerial attention was brought to bear on this issue, with the resultant changes in how men and women were to be roomed. Unisex [22] accommodation

realizes significant organizational efficiency. It creates an increased bed capacity by ensuring that no bed remains empty due to it being inappropriate accommodation in relation to the patient's sex. One administrator I interviewed about the new policy viewed unisex accommodation as a way of "letting go of outmoded rules and moving into the new millennium". For administrators, whose focus is on the efficient use of resources, it makes sense to develop policies that alleviate an apparently wasteful use of hospital space and of hospital workers' labour.

What remains unexplicated and invisible within the technologies of counting, as the figures are substituted for the local activities they purport to represent, is the new work nurses (and patients) may undertake in order to function within the new systems. Because the ADT data is focused on efficient use of resources it emphasizes (foregrounds) costs – the element of knowledge about patient care that managers must attend to. It drops away, or displaces, other aspects of patient care that nurses might give priority to. For example, the pain management of a patient who is being sent home following a shoulder surgery, or the discomfort of my friend Mary, a single woman of sixty-seven experiencing unstable angina who spent 16 days on a heart monitor awaiting a coronary angiogram. Mary was accommodated in a room with three men with whom she shared a bathroom. She told me that this was a difficult situation for her. She kept the curtains pulled (and pinned) around her bed. She mentioned that she felt her modesty and privacy were difficult to maintain, that she felt isolated, at times embarrassed, and occasionally vulnerable, as she adjusted to sharing sleeping, toilet, and bathing space with men. These issues become a "preference" that hospitals cannot accommodate.

As detailed data about the various costs of the many activities being accomplished in hospitals are made available to managers they are expected to make decisions and to intervene in aspects of patients' hospital care. One patient services manager explained how he uses, and is accountable to, the ADT generated data:

> We need these statistics for a couple of reasons. We need those ones that the ministry insists on and I need some purely to do my work. I use them as backup for proposals. I guess every second day you get involved with discussions with other hospitals in comparative talks. You get at the table in budget discussions or whatever, and you can talk statistics at people. We can say "okay yes, well we do 280 joint replacements a year, so we *do* need more money in our joint program". Utilization and length of stay are big issues with the region. They say, "Look here, what's happening here? You're not utilizing well"....and certainly, in our discussions with the ministry, in order to receive any extra funding, for the joint program for instance, they talk about length of stay and utilization a lot.

During the interview with this manager he pulled sheaves of paper out of his briefcase explaining how he had only just returned from holidays and, the previous evening, had taken the "period statistics" home to review them. Embedded in his talk about his use of statistics is the reliance he places on them for his decisions:

> At any given time we can pull the statistics. Actually, we're not doing very well right now. We've started to vary a little bit with our hips and knees, probably by a day or two here and there. We have to get better at that.

When, while looking at the statistics, he says "we have to get better at that", he is referring to his managerial responsibilities that are organized through the "facts" generated by the computerized systems of counting employed by the hospital. He uses his statistically generated knowledge when interacting with people from the ministry of health, for whom "utilization and length of stay are big issues". As a manager it is his job

to initiate strategies to address the problem of patients and practitioners who "vary a little bit", who stay in the hospital "a day or two longer" than their allocated five days. It is his responsibility to organize professional practitioners and hospital employees to direct their work towards standardizing patient length of stay. For him, the ADT data provides the substrata of "efficiency", the virtual reality toward which his everyday work is directed.

The ADT system produces knowledge about the daily acuity of the hospital (or, as one nursing team leader put it, how "hot" the hospital is). Cumulatively knowledge is generated about average patient length of stay, and average length of stay per procedure. A hospital's performance is discovered through the kinds of measurements and comparisons ADT offers. Through the ADT system, what gets measured and acted upon in relation to the hospital experience (and the nursing care that patients require) is increasingly shaped by the overriding reference to costs.

ADT data is used to administer funds: Extra-local knowledge

Certain funding decisions are made based on a hospital's "performance" as it can be shown by the ADT data. In health care reform and hospital restructuring, hospital administrators, regional health authority administrators and bureaucrats at the ministry of health all make use of the ADT generated data to make decisions such as the closure of hospital beds, the closure of hospital wards, or the closure of entire hospitals. Knowledge of movement of patients through cost-relevant spaces is used to maximize "efficient" use of resources not only in the day-to-day discharge or sex-segregation practices being managed locally, but also to inform "extra-local" decisions being made by managers and administrators far removed from the actual sites of patient care practices.

Reconstituted managerial knowledge generated by the ADT system organizes hospital restructuring (and nurses' work) from several different organizational levels. Institutional ethnographers (G. Smith, 1995; Kinsman, 1995, Mueller, 1995, Griffith, 1995, Ueda, 1995, Pence 2001) refer to this geographical and chronological "layering" of organizing levels as "local" and "extra-local" arenas of action. At the local ward/hospital level, the ADT system is used by bed utilization clerks to place patients and to determine how patients enter and leave a nurses' work purview. ADT generated data is used locally by nurse managers to make decisions about how available bed space is to be utilized. It is used to manage scarce resources to determine, administratively, whether patients are to stay the night, and how patients must share space. At this local level of managerial decision making, clinical relevancies about how patients are to be accommodated, or which patients require overnight care, fall to the back while cost-relevance is brought to the fore.

At the extra-local level the hyper reality of the numerically based data is directly related to funding strategies and is used more broadly to restructure hospital care. The ADT data is regularly submitted to the Ministry of Health where it is used to generate "provincial averages" and to provide ongoing data upon which to base funding formulas. ADT generated statistical data is aggregated and fed back to the hospital managers in the form of "provincial averages" and "benchmarks". Statistically, "like" hospitals and "like" regions are compared one to another so that health care administrators can "know" about efficient and inefficient hospitals as they compare to other regions. Standard statistical

measurements offer the kind of description of hospital performance and health care delivery that produce unassailable accounts. For instance, the patient service director's knowledge about how "well" patients do at home following shoulder surgery is "factual". It is also the case that the manager knows with certainty that he "has to get better at that" when reviewing statistics about patients who are undergoing hip and knee surgery. The knowledgeable work of these managers and the accounts their work generates produce the hospital "efficiencies" that are the imperative of cost containment organized by health care reform.

I have shown Nurse Linda scurrying about making room for incoming patients as local activities of nursing care are aligned with the textual hyper reality capable within the ADT system. Her work is also aligned with the extra-local decision makers. A hospital president I interviewed described how, in 1997, the regional hospital he administers received funding for "673 acute in-patient days per 1,000 population". He explained how, statistically, this translated into two overnight beds per thousand people in the region. He described how the same-day-admission program and improved ambulatory care procedures had generated improvements in the statistical data being sent to ministry officials (via the ADT system). As a result of collecting this kind of data the ministry developed new "benchmark targets" for "acute in-patient days". At the time of this interview (1999) the funding formula had been reduced to one and one half beds per thousand population. Hospitals that can demonstrate effective bed utilization are supported by increased (targeted) funds to support ambulatory care programs (Interview, regional health board official, July 2000). Funds for inpatient programs are reduced and

beds are closed. In a discussion about the management of hospital resources Kerr, Glass, McCallion and McKillop (1999) define buildings and bed capacity as a "fixed investment". They argue:

> A hospital can only achieve maximum possible efficiency when fixed investments are fully utilized. . . If capacity under-utilization exists, fixed costs are higher than necessary and average resource costs of treatment are not being minimized. Therefore, while some degree of spare capacity is essential to meet periods of peak demand if health care of satisfactory quality is to be maintained, excessive spare capacity generates inefficiency and needs to be identified (p. 640).

In the case of my informant, the hospital president, "excessive spare capacity" (being generated by the introduction of efficiencies such as the ambulatory care program) is being managed through changes to funding. This translates into fewer hospital beds for this geographic region. Nurse Linda's activities discharging Ms. Shoulder reappear as statistical data generated via the ADT system. Nurse Linda's practical work coordinates with the work of the statistically abstract technologies to accomplish discharges that meet the standard for length of stay and also help to meet the "benchmark targets" for "bed-days per thousand population". Together they accomplish the goal of a restructured hospital and the demonstration of "efficiency".

Computerized systems such as the ADT system have been adopted as indispensable time-savers that make the work of tracking, locating and assigning patients to beds more expedient. However, they produce much more than mere convenience for front-line workers who can now make quick "computer entries" to report a patient's status. Cumulatively, each entry, tracked, monitored and categorized produces a powerful regulator of hospital activity.

Alternate level of care (ALC): Appropriate and inappropriate use of nursing labour resources

The efficiencies sought by hospital restructuring are not only about managing waiting lists, rationing the number of beds available and organizing systems to ensure that the beds are full and productively utilized; nor are they only about the efficient (sped up) placement of patients in and out of unisex beds. Restructuring for efficiencies also includes sophisticated systems developed to constitute managerial knowledge about patient's needs and to inform cost-relevant decision-making about a patient's "appropriate" or "inappropriate" use of scarce labour and treatment resources. Alternate level of care (ALC) is one such system. Developed by the Canadian Institute of Health Information (CIHI), ALC is a system to screen and designate patients in relation to their suitability (from an administrative perspective) for admission into an acute-care hospital. It is a system that organizes a business-oriented knowledge, for managerial response, about apparent inefficiencies in hospital care. In CIHI literature an ALC patient is defined as "a patient who no longer requires acute care but continues to occupy a bed for any reason" (CIHI, 1997). ALC is a health information strategy that organizes how patients are "known", both by managers and by nurses. The ALC designation works to restructure a hospital's global use of labour resources by producing information about how some individual patients place inappropriate demands (from a cost-oriented perspective) on skilled nursing labour. Through the operation of the technology, managerial knowledge about patients is abstracted from patients as individuals. Like the ADT system, the ALC produces a textual hyper reality but in this case, the hyper reality is about patients' needs rather than available space. As such, the ALC assists

administrators to make decisions about rationing the type of nursing and medical care certain patients may access.

What I draw attention to here is how ALC data is generated, how it is reported and aggregated. I explicate the system through which abstract information about individual patients' complex circumstances is numerically organized and understood by managers (and by nurses) to be an effective and reliable indicator of hospital activity which can assist healthcare managers in utilization management of labour resources. In Chapter Four, I develop this analysis further, describing how ALC turns up in the actual practices of nurses' clinical work with patients.

How Alternate Level of Care works

ALC is a new administratively relevant way of knowing about patients. Despite the fact that the ALC designation is an administrative, cost-oriented category, (not a clinical one) nurses and physicians are relied upon to screen for, and initiate, the ALC process. For the most part, it is nurses who work to identify patients who meet the ALC criteria developed by the Canadian Institute of Health Information. It is nurses who complete the ALC designation form and who work to secure a physician's signature. A nurse I was working with during clinical update was looking after an eighty-four year old woman who had fallen and broken her hip. The woman lived independently prior to her fall. In the verbal, shift change report, the nurse said "shouldn't we be thinking about making her ALC?" Despite this elderly patient's ongoing need for assistance to wash and to walk, the nurse looking after her recognized that this patient was no longer an "appropriate" recipient of her nursing care and was preparing to invoke the ALC designation.

Institutionally, designating a patient ALC initiates several responses. An ALC designation form, completed by nurses and signed by a physician, is the first in a sequence of documentary processes that move (as texts) into extra-local arenas that eventually intersect with the CIHI. The actual ALC form used by nurses to initiate an ALC designation is a "tick box" form (Appendix C). The ALC text directs nurses to actively monitor and report "barriers to discharge". The barriers are organized under the headings "community", "hospital" and "patient/family". "Lack of availability of a family caregiver" is one of the reasons a nurse may tick when completing the official form that designates a patient as ALC. Initially, when a physician authorizes the ALC designation, the hospital's admitting department is notified. The date of the ALC designation is noted, and the patient is given a new numerical code used each time any information about the patient is entered into the hospital ADT database. Through the ADT database the hospital is able to accrue local statistical data related to the numbers of ALC patients present in the hospital population. The ADT software program is also used to develop local statistical information related to total "ALC days" over a period of time. Information related to ALC patients is tallied monthly, and along with other ADT generated statistics, is regularly reported to the BC Ministry of Health and ultimately to CIHI. At CIHI, "hospital summaries" are compiled and distributed back to all comparative "peer" hospitals. Summaries contain statistical comparisons among hospitals, such as "percentage ALC days" relative to "total patient days". ALC designated people (most often particular older people in particular beds) are objectified,

reappearing textually as total cases, caretypes, resource intensity weights, and a percentage of hospital weighted cases (Appendix D).

In this textual hyper reality local events are re-organized (textually) so that they correspond to the business/cost-oriented discourse of reform's efficiencies. The CIHI's interest in collecting data about patients who are inappropriately taking up acute care resources (CIHI Bulletin, 1997) is an extension of the sort of knowledge being gathered through the ADT system. It represents an increasingly sophisticated interest in rationing which patients get an overnight hospital bed; how long, on average, certain categories of patients stay in hospital; how length of stay (LOS) can be reduced and so forth. ALC foregrounds the business-orientation of rationing labour resources and backgrounds other issues that emerge in the care of frail elderly people who cannot be sent home and who continue to occupy hospital beds for any reason. A CIHI Bulletin dated May 28th 1997 was posted on the wall of a nursing unit where I was collecting data. Questions and answers addressed in this bulletin offer clues into the interests and processes of the ALC designation. The bulletin covered issues such as: "Why is it important to identify ALC days?", "Who identifies ALC?", When is ALC documented on the patient record?", "Does ALC status mean that the patient must begin to pay for treatment?", "Does ALC designation affect the Resource Intensity Weights (RIW's)?", "How does the Health Ministry use ALC data?" (CIHI Bulletin, May 28th 1997). The bulletin described how the ALC data is useful to assist administrators to "estimate the impact ALC patients have on the hospital's resources, services and workload" (CIHI Bulletin, May 28th 1997).

The professional commitments of nurses, as they are learned in nursing school and expressed in the work that nurses accomplish during a shift of duty, are oriented to the details of patients' experiences. A nurses' shift of duty is continually being shaped by the particularities of each patient in her care who will make demands on her time related to their individual needs. Nurses are oriented to patients, to their physical conditions, their expression of emotions, and their social complexities. Nurses' work, absorbed in the details of patient care, is oriented to individuals. This is the central contradiction I point to here. The focus of the CIHI bulletin is on standardization. It cannot accommodate nurses' commitment to individualize care to their patients.

The ALC category is an important instance of how health information technology works to coordinate patient's needs and nurses' interventions with a business-orientation of resources and costs. The focus of the CIHI bulletin supports my contention that ALC is a "business-diagnosis", unrelated to the usual interests of doctors and nurses in individual patients. Nonetheless, nurses are good at doing the work of soliciting information from people and it is nurses who are relied upon to screen and initiate the ALC designation. Through their ALC screening and designating work, nurses participate in the transformation of nursing into increasingly business-oriented modes of operation. Nurses' interests and the needs of people who require hospitalization, along with the "traditional" interests and expertise of nurses who care for them, are not evident in the textual representations of ALC. [23]

During the course of this research, the community hospital where I first noticed ALC being used instituted major restructuring in the funding designation for "types" of beds. Responding to trends in their ALC data, twenty acute care beds were closed on a medical wing of the hospital. Minor renovations were made and these same beds were reopened as long-term-care beds. All the nursing staff in the adult medical/surgical units were given layoff notice. A reduction of the complement of Registered Nurses (RN's) and Licensed Practical Nurses (LPN's) was achieved as the 20 "new" long-term-care beds were staffed predominantly by lesser-qualified Long-Term-Care Aides. New work rotations were developed and the RN's and LPN's were required to reapply for the depleted jobs under the jurisdiction of the British Columbia Health Labour Relations Act. Re-structuring bed designations and restructuring nursing labour is organized by the "facts" compiled by the CIHI data within the textual, cost-oriented domain of ALC. The textual representation, – the "facts"– generated by a nurse completing the ALC designation form quickly loses sight of the individual patient the forms purportedly represent (for example, an eighty-four year old woman who fell and broke her hip, whose nurse suggests: "shouldn't we be thinking about making her ALC"). The nurses' traditional terrain of assessing and intervening on behalf of a patient who is not yet well enough to return home, is corrupted through her participation in the ALC process. Textually represented as someone who lacks family support and who is inappropriately occupying a hospital bed, the facts about this elderly patient pass through the admitting department, the ADT data base, the ministry of health and the CIHI to rebound back into the local setting as administrative decisions to close wards and lay off nurses.

Health information technologies such as ADT and ALC generate and process knowledge that eventually affects nursing care. These technologies shift the locus of control over patient care. They produce information that authorizes administrative decisions to take priority over the expertise of nurses and physicians. For instance, whether or not a patient requires overnight nursing care following a surgery. If a patient meets criteria for admission to hospital it is administrators who decide where and how that patient will be accommodated within the rationed resource of hospital beds. Indeed when a person cannot be discharged from the hospital the "system" identifies whether or not that person is an "appropriate patient" to receive nursing care. Important decisions about hospital operations are based on knowledge produced by health information technologies. Labour resources such as staff mixes are allocated based on knowledge generated through health information technologies. Hospital beds and hospitals themselves are funded and resourced based on what health administrators are apparently able to know and to show about activities going on in hospitals. The capacity to generate administrative knowledge is at the heart of hospital restructuring. While it is putting efficiency into the forefront of health care, it is also significantly altering how/what health care is provided to whom. I will argue throughout the rest of this dissertation that this has unforeseen and troubling consequences for nurses and patients.

Reconstituting knowledge about hospital restructuring for accountability

In reformed and restructured hospitals, where operations are being significantly changed, hospital administrators are placed under intense scrutiny. They are faced with multiple demands, not only competitive funding cultures and changing accreditation standards (see Chapter Two), but also increased public/political pressures to feed an interest in

health care that is focused on a "need to know more about what we are getting for our money" (Toronto Star, 1999, p. A6). "Accountability" is becoming a key feature of health care reform. Indeed the much anticipated 2002 Romanow report called for a revision of the *Canada Health Act* to include a *Sixth* Principle of Accountability.

Across contemporary society a phenomenon is arising that places increasing trust in numbers, and the apparently objective, scientific approach to "knowing" about what is happening (Porter, 1995; Rose, 1991). Numerically based information is represented as a neutral and reliable mode of knowledge upon which to make decisions. In contemporary organizations, numbers "work". With numbers things get done. These systems of "knowing" are both pervasive and alluring. Yet, what I have been describing in my analysis of the ADT and ALC systems, is that these technological approaches to management are not objective or neutral. They insert a very particular way of knowing about what is going on that refutes other ways of knowing. They replace a trust in professional knowledge with other "facts". What is happening in hospital care, as professional caregivers would describe it, slips away and the abstracted account henceforth 'stands in for' what actually happened.

The patient satisfaction system, the last technology analyzed in this chapter, represents the "end-stage" of managerial systems designed to produce "information-based knowledge" about what is happening in order to accomplish and demonstrate "improvements" in hospital care. The emerging managerial interest in "patient satisfaction" emphasizes not only the general trend in the new belief system in objective

forms of knowledge, but it is also part of pervasive "consumer" discourse that emphasizes market-like, cost-relevant interests that support and buttress the programs and efficiencies of restructured hospitals. Again and again services and programs are being pared for cost-reductions and it is incumbent on managers to demonstrate that the cuts and efficiencies are not detrimentally impacting the standard of health care. The emerging emphasis on patient satisfaction (CIHI 2000, Mcleans 2003), combine with technologies such as ADT and ALC, to produce the growing penetration of business-like, corporate principles and practices being inserted into the organization and delivery of hospital care (Armstrong and Armstrong 1996, Armstrong et al. 1997, 2000).

Patient Satisfaction

"Patient satisfaction" is part of the managerial effort towards accountability in the public sector that is "increasingly defined in terms of outputs, value for money and monitored standards of effectiveness, efficiency and productivity (Townley, 1996, p. 565). I use the patient satisfaction survey my aunt and I responded to, introduced in Chapter One, to develop a textual analysis about how the survey is used to constitute managerial knowledge that can be called "patient satisfaction". Earlier, both in Chapter One and Chapter Two, I briefly described the survey my aunt and I responded to (Appendix E). I pointed out that despite over 100 multiple-choice questions, the survey tool could not accommodate stories Hannah and I had to tell about our various interactions with nurses and doctors. The survey tool required us to collate and condense our manifold experiences, to "sum up" our encounters within a framework of interests that were mainly not ours.

Hannah's and my difficulties "inserting" our experiences into the form suggests that the point of conducting a patient satisfaction survey may not actually be to discover and document our *experienced* level of satisfaction. Rather, the survey is interested in documenting "something else". As an organizational document, one can assume that an organizational purpose should be looked for. Using Smith's (2001) method of textual analysis I explicate the patient satisfaction survey, as an organizational text that "is intertextually connected with a textually organized complex that can be explored ethnographically" (p. 192). An institutional ethnographic reading of the survey re-places it within its discursive home and uses textual clues to discover how it is (or might be) organizationally activated.

The survey, I discovered, is "nested" in a broad set of institutional processes and documentary practices (G. Smith, 1995).[24] The package of materials Hannah received in the mail included the 18 page booklet: *Through the Patients Eyes:Patient Survey.* It also included an introductory letter that described the survey materials. The letter explained that Hannah's name had been drawn from a random sample of patients admitted to the hospital. To conduct my ethnographic textual analysis I obtained a copy of the summary report of a 1995 survey that had been conducted at the hospital: *In Pursuit of Quality: An Assessment of the Quality of Care and Quality of Worklife at (The) Hospital.* The only access I was granted to documents generated by the 1998 survey included a short (2-page) document titled : *In Pursuit of Quality1998: Brief Summary* and four pages (16-20) of the full 1998 report – *In Pursuit of Quality 1998* – that contained the statistical breakdown of patients' responses to thirteen of the 1998 survey questions. The 1995

summary report referenced a 1993 publication *Through the Patient's Eyes: Understanding and Promoting Patient-Centred Care* (Gerteis, Edgman-Levitan, Daley and Delbanco, 1993) which I was able to access in order to investigate the organizational purposes of the satisfaction survey. I also interviewed the Coordinator of Hospital Evaluation at (The) Hospital and a Clinical Nurse Specialist who was involved in responding to the survey results. These documents and interviews, along with Hannah's and my actual experience of her hospitalization, provide the core material for my analysis.

Patient Satisfaction: How it works.

To develop the institutional ethnographic reading of patient satisfaction I go back to the actual activities of Hannah and myself completing the survey. The introductory letter that accompanied the survey identified how the information that we were to provide would help the hospital "improve the quality of care received by patients and their families" (Introductory letter). The survey itself was divided into fourteen headings. It opened with a statement about "changing" and about "patient centred care" which is a "way of organizing and delivering improved programs". The introduction to the survey reads:

> We're Changing to Make Your Stay Better
>
> Patient centred care is at the very core of (The) hospital's vision for the future. It is a way of organizing, designing and delivering improved programs and services to you and your family.
>
> Your Patient Centred Care Team represents your care providers, from the cleaning staff to the doctors. The team looks at the way we are meeting your needs and concerns, such as physical comfort, emotional support, family involvement and availability of

> information. The team is working to improve the delivery of health care to you and your family. (Survey document).

Hannah and I were both interested in improving the delivery of health care. Patient centred care, physical comfort, family involvement and the availability of information are important values that made sense to us. We were responsive to the opportunity to provide information that would assist the hospital to improve. Hannah was generally very satisfied and enormously grateful for the care she received and for her successful recovery. She was interested in communicating this. I was more critical and was interested in letting the administrators know where I had observed gaps in the care my aunt had received.

As I described in Chapter One, responding to the survey was not a simple undertaking. For instance it was impossible to accurately answer the question: "In terms of confidence and trust, please rate your relationship with the nurse(s) on your unit?" The relationships Hannah had within the varied units, with the varied nurses depended very much on the acuity of her condition, and the experience and approach of the particular nurse she was encountering. Despite occasions when she had a great deal of confidence in the nurses, and times when she felt the nurses were very available to her when she needed them, Hannah responded that her confidence and trust was "fair" and that the nurses were available "sometimes", in order to account for the times when she felt the nurses had not responded to her needs. The actuality of what Hannah and I encountered during our hospital experiences was distorted by the patient satisfaction survey when my aunt and I consistently chose the "best" but essentially inaccurate responses to the questions.

Hannah's and my comments and responses were dominated by the questions, and the answers that were provided in the "multiple choice" format. The text inserted its own interests in "admission and orientation" and "communication and relationships", which may or may not be the interests of respondents. Hannah and I did attempt to interject our own comments into the text-dominated conversation. For instance, Hannah, unasked, wrote the actual name of a doctor in whom she had a great deal of confidence, and I penciled in the comment "when requested" beside a question about information we received. Despite our remedial work on the text, it "fixed" what we could say about our experiences.

The survey and its companion texts provide the clues into the social organization of the constitution of managerial knowledge about "patient satisfaction". The opening statement of the survey – about "changing" and about "patient centred care" which is a "way of organizing and delivering improved programs" (Survey, p. 1) provides the hints about exactly what was being "fixed" by the survey document. The introductory letter that accompanied the survey introduces how the "core value of (The) Hospital is to put the needs, safety, concerns and outcomes of our patients first. Striving to become a *patient and family centred* hospital is at the very core of the values of (The) Hospital" (Introductory letter, opening statement, emphasis mine). The preamble to the 1993 summary document titled *In Pursuit of Quality: An assessment of the Quality of Care and Quality of Worklife at (The) Hospital* opens with the statement:

> The vision of (The) Hospital is to create a humane, *patient centred*, academic health

> sciences centre where physicians, staff and volunteers are committed to fostering an environment that enhances the needs of our patients. One way to create such an environment is through *patient centred care* (Summary document p. 1, emphasis mine).

What is glimpsed here, and what my analysis supports, is an institutional ideological construction of "patient centred care". Although not immediately apparent when activated within a "colloquial" reading of "patient centred care" (as read by Hannah and I when we encountered the survey) the institutional reading introduces a particular construction of patient centred care that activates a different (and, I argue, a technological and enterprising) construction of both patient satisfaction and patient centred care. The Patient Centred Care referenced in the survey documents is the re-engineered work process (described in Chapter Two) that Hannah and I were experiencing throughout her hospitalization. It is this re-engineered work design that the survey technology is designed to assess and improve.

Tracking the texts reveals how the survey is not just a method of collecting information and feedback but is also a part of the hospital's management strategy. It is part of a broad set of managerial technologies that can be used to assist in "organizing, designing and delivering improved programs". The introductory letter accompanying the survey asserts that the information gathered by the survey will be shared with "our staff and with the professional colleagues" to "help us improve the quality of care received by patients and their families" (Survey, introductory letter). The patient survey is developed to be useful to managers, not only as a method for providing accountability, but also as a means of organizing staff and professional colleagues towards further improvements.

Further investigation reveals a rich management literature on "Patient Centred Care" through which the formal reading of patient satisfaction and patient centred care can begin to be understood. According to publications from the Registered Nurses Association of British Columbia (RNABC, 1996a p. 3), patient centred care is a "centralized" approach to care "organized to meet the needs of the client and provided at the convenience of the client". It is part of an "interdisciplinary patient care delivery system" which attempts to bring together in one unit "a greater variety of services and personnel". Specifically, patient focused care is based on the premise that: "multiskilling can occur among professional disciplines or between professionals and assistive personnel. Delivery of patient care within a service unit is coordinated by self-directed work teams comprising professional and assistive multiskilled health care workers" (RNABC, 1996a p. 5). According to the RNABC, the reported benefits of an interdisciplinary patient care delivery system include "improved coordination of client care, greater accountability for the effectiveness and quality of patient care, improved strategic planning (and) improved cost control" (RNABC, 1996b, p. 3).

The patient satisfaction survey my aunt and I responded to is connected into the broad literature about cost savings possible within the re-engineered hospital work processes of patient centred care. The survey itself mirrors a 1993 publication (Gerteis, Edgman-Levitan, Daley, Delbanco), referenced in the summary document, entitled *Through the Patient's Eyes: Understanding and Promoting Patient Centred Care.* The survey my aunt and I received in the mail was also called *Through the Patient's Eyes.* Gerteis et al. discuss patient centred care as a means to:

> Provide common ground for patients worried about health and well-being, managers worried about competition and efficiency, clinicians worried about quality of care, and payers worried about cost-effectiveness to talk and work together. We write primarily with the administrators and senior managers of hospitals and health care facilities in mind, to whom we offer a framework for thinking about, assessing, and managing the quality of care from the patient's perspective (p. xiii).

The intertextual connections within this textually organized complex – the summary document, a publication in the management literature, and the survey itself – reveal how knowledge about patients' experiences, responses, concerns, etc. is "worked up" (and down) through nested layers of managerial and organizational knowledge to be shaped into a useful form for managerial action, the "common ground" that Gerteis et al. (1993) refer to.

The textual complex within which the patient satisfaction survey is embedded includes the headings that organized the satisfaction survey tool. These headings adapted from the *Canadian Patient Centred Hospital Care Study Questionnaire* are a reconstituted form of "seven primary dimensions" that Gerteis et al. (1993) maintain "capture what is important to patients" (p. 5). [25] The seven primary dimensions about what is important to patients were themselves developed using a survey and sampling technology that included a "brief questionnaire" administered through a telephone survey, in conjunction with focus groups with physicians and non-physician hospital staff, and a review of the "pertinent literature to help flesh out the context of the patient's observations" (Gerteis et al. 1993, p. 5). Gerteis et al. conceptualize a "patient's perspective" that produces a theorized[26] version of what patients want. For example, according to Gerteis et al. "coordination and integration" is one dimension that is important to patients. In my experience, it is hard to

imagine patients using this sort of language when asked about what is important to them when hospitalized. I am emphasizing that the "seven primary dimensions" of patient centred care that formed the conceptual basis of the survey questions Hannah and I responded to, and that Garteis et al. (1993) claim are "important to consumers" (p. 10), did not capture the omitted/flawed components of Hannah's daily, specialized nursing care. It is this comparison of experiential with managerial knowledge that allows me to argue that the patient satisfaction survey technologies distort and gloss over what is actually happening in hospitals. In the instance I study here, I argue that the knowledge generated through surveying patient satisfaction is embedded in a dominant, consumer orientation that buttresses the re-engineered approaches to organizing care popularized in the health management literature.

My analysis suggests that the managerial (ruling) frame for the patient satisfaction surveys my aunt and I responded to is constructed primarily for administrators and managers whose responsibility it is to accomplish "quality" care. I have shown how the patient satisfaction survey is linked into the discourse of patient centred care. Through this discursive linking managers are able to coordinate patients' and clinicians' interests along with somewhat contradictory ones – such as costs – and to create an authoritative "knowledge" upon which decisions can be made.

This comparatively recent and evolving managerial regard for an objectified measure of overall patient satisfaction (CIHI, 2003) constitutes a new managerial interest into the standard of professional care being afforded to patients in hospital. Numerically based,

and apparently objective and neutral, it constitutes the managerial view about satisfied patients. Rochchiccioli and Tilbury, (1998) who write about *Clinical Leadership in Nursing* (1998) offer a related set of instructions to managers about the benefits of viewing patients and coworkers as (satisfied) customers:

> The primary groups with a stake in health care outcomes are patients, families, physicians, nurses, other health care professionals, insurance and provider organizations. Leaders in quality improvement point out the value of viewing each stakeholder as a customer. Viewing patients and co-workers as customers has sensitized providers to the importance of patient satisfaction and teamwork in providing quality care (p. 238).

New managerial approaches to "sensitizing" providers to the importance of patient satisfaction, to teamwork and to quality hold different interests and relevances than those nurses, physicians, or patients might have previously understood as good (quality) care. For instance, du Gay and Salaman (1992) examine the discourse of "customer" within contemporary business literature and conclude that quality is defined as giving customers what they want, and success hinges on a workforce which can be relied upon to develop new ways of working which demonstrate innovation, flexibility and customer responsiveness. In hospitals, quality care seems to be acquiring a new definition. Patient Centred Care represents a new innovative and flexible way of working that supports this new definition of quality. The patient satisfaction surveys reflect a changed managerial interest in patient care, one that is organized to attend to issues of "customer responsiveness".

Reconstituting patient satisfaction managerially organizes both what is accounted for in patient experiences, and also, how that account is to be read. Constituted within the

managerial relevancies of efficiencies and costs, patients' problems, including their dissatisfaction, are not read as clinical concerns about important details of daily care being overlooked. Rather, they are constituted as marketing problems:

> Patients who reported problems in these areas (basic needs) were about four times more likely to say they would not return to that hospital in the future, and nearly nine times more likely not to recommend it to friends or families than those who did not experience such problem (Gerteis et al., 1993, p 242).

This reading about patient's "problems" introduces issues of patient (customer) loyalty and issues of market-like referrals (family and friends). In Hannah's hospital, (The) Hospital summary report (1995) of the patient satisfaction survey included a section entitled "Assessment of the Quality of Patient Care". This report echoes the marketing frame of the "for profit" system Gerteis et al. write about. At Hannah's hospital patients' problems are discussed as "satisfaction ratings" and are used to compare among Clinical Practice Units:

> With respect to the rating of Overall Care, 79% of patients rated the hospital as either "Very Good" or "Excellent" . . . Ninety percent of patients would prefer the same hospital if they were to require hospitalization again; and 96% would recommend (The) Hospital to their friends. ... Differences among the Clinical Practice Units (CPU's) were seen with respect to patient satisfaction. Patients in the CPU's of medicine were significantly more satisfied than patients in the CPU of psychiatry, and patients in the CPU's of Medicine and Surgery were significantly more satisfied than patients in the CPU of Orthopedics (Hospital Summary Report, p. 3).

The ratings are used to insert a competitive organizational approach to patient's problems. Provinces and local hospitals and Clinical Practice Units are "judged" through these survey results. Management decisions are made and justified in relation to survey findings. Information gathered through hospital patient satisfaction surveys provide a data set "whereby health-care organizations can assess their level of performance against

a set of nationally applied standards" (Smith, Armann-Hutton, Innions and Hutton, 1999, p. 384). Hospitals adopting businesslike customer satisfaction technologies enter competitive market relationships into their efforts to manage the services they provide. Survey results are used to exert organizational control over what happens in a professional practice.[27] [28]

But, as I have shown, patient satisfaction surveys reconstitute "satisfaction" – what patients know/what they experienced—into managerially relevant categories that align with the management agenda for reducing costs while at the same time showing "success". Surveying patients about their levels of satisfaction is one of the newest components of the increasingly pervasive and appealing use of numerical data that is being used in an attempt to get an objective account of hospital "outcomes". It is part of a system of constituting a managerial hyper reality, producing an authoritative knowledge, about what patients think about the care they received. It contributes yet one more management technology that stands as an apparently reliable source of knowledge about what is going on in Canadian hospitals. It contributes to the vast system of "information technologies" that displace the need for managers to trust and rely upon professional knowledge. It is part of the "new accountability" that according to Romanow (2002) should be entrenched in the Canada Health Act. Nonetheless, I use this analysis to argue that knowledge being generated by patient satisfaction surveys leaves serious knowledge gaps about the adequacy of hospital care being provided to Canadians.

Chapter four conclusion

Technologies such as the patient satisfaction survey combine with the other technologies I have been describing to create an impermeable "accountability" system. Powerful textual hyperrealities generated through technologies of counting are invoked to provide official knowledge about "improvements" in health care. Recall the issues raised during my meetings with the Nurses United for Change (NUC) outlined in Chapter One. During the NUC activism (1995-1999), the hospital where the NUC nurses were employed had undergone a series of restructuring evolving from a "Nursing Department" into a "Department of Patient Services" with the latest initiative (2001 to present), "Integrated Programs". At the same time, at the NUC hospital, between 1994 and 1997, eight formal reviews were conducted. A 1996 review, the "External Nursing Review", was organized "to assess the impact of restructuring of the nursing department". The NUC nurses secured a meeting with the reviewers where they outlined many troubling incidents of practice (blood transfusion errors, medication mistakes, patient's going home with vaginal packing in place, and so forth). Despite hearing these stories, in their final report, the reviewers wrote: "overall the consultants were impressed with the quality of care throughout the department" (Nursing Review document). In their report, the reviewers explained:

> The purpose of the review is to briefly review and compare acute care nursing staffing levels at (The) Hospital with other hospitals in its peer group. Workload, financial data and schedule hours are evaluated for each acute care cost center within the Nursing Department, both for comparisons over time and for comparisons across peer group hospitals" (External Nursing Review, June 19th, 1996).

The reviewer's findings were determined by comparative statistical analysis related to internal "cost centres" and external "peer hospitals". The textual comparisons told the

reviewers something about "quality". My participant observations with Nurse Linda and with the nurses of NUC told a distinctly different story. Even nurses' own on-the-ground experiences, told to the consultants in a meeting organized by NUC, were, in the final report, glossed-over and subordinated to the hyper reality of the managerially relevant knowledge.

Overall, my argument in this chapter is that health information technologies organize a business-orientated knowledge for managerial response. The systematized organizational solutions I have analyzed are informed by an administrative technological knowledge supported by "health information systems". The technologies build "factual accounts" (a managerial hyper reality) about how beds are utilized, how labour resources are expended, and how hospital restructuring can be shown to produce an adequate quality of care. The business-oriented knowledge about what is going on in health care is generated by *cost-relevant* data that systematically excludes other knowledge that is relevant for other interests and issues including those of nursing. The social organization I describe here produces a ruling knowledge about an apparently "improved" system of health care being offered to Canadians. Standard statistical measurements being generated and used by hospital administrators offer a description of hospital performance and health care delivery that contests (and I argue, overrules) what nurses on the ground are saying about what is actually happening. In part, the health information technologies at work in hospitals produce the puzzling disjunctures experienced by the nurses I have been working beside. The contextualizing features of nurses' and patients' everyday/everynight experiences are not discernable in the figures generated to capture

what is happening. The "facts" about what is going on in hospitals (patient satisfaction surveys, nursing review summary reports and the like) are rendered "objective" as they move away from the located place where they are generated. Paradoxically, the objectified accounts and facts constructed within the various textual media that I explicate in this chapter, ricochet back into the actual setting, organizing and influencing the activities of nurses.

Chapter Five

Organizing practices of reform: Enforcing nurses' participation

Introduction

This chapter explores how nurses are actively involved in practices of health care reform. I argue that their work is crucial to the restructuring of hospital care. Strategies for restructuring for cost efficiencies do not always find an easy fit with nurses' professionalism. Nurses, with their self-regulating mandate, might be expected to resist anything that interferes with their own ideas about how to maintain a high quality of patient care. However restructured hospital practices include enforcement strategies to engage nurses' cooperation and to guide nurses' work to align with the new efficiency mandate. Even though "reforming" nursing practice may not be the explicit agenda of health care reform or hospital restructuring, nurses learn to participate properly in order for the efficiencies to be realized. Restructuring changes nurses' knowledgeable practices. The new mode of hospital organization teaches nurses to believe in, and take part in, the cost-relevant practices.

In this chapter my observations of nurses discharging patients allow me to trace the ruling relations that organize these activities. I show how discharge becomes a nursing priority subordinating caring activities. Ethnographic data about nurses' ALC activities offer the basis to explore how a business-like, cost-oriented approach to clinical decision-making is folded, imperceptibly, into nurses' "traditional" ways of thinking about patients. I then move to an analysis of the development and implementation of a clinical pathway which

displays how managerial technologies are used, quite explicitly, to alter nurses' "mind-set" and how the new mind-set of "efficiency" is actively enforced. Finally in this chapter, I bring attention to the "primacy of the discharge" describing how, across British Columbia, hospitals have systematically adopted or developed strategies to streamline physicians' and nurses' discharge practices.

Physical pressures enforce nurses' compliance in bed utilization activities

The physical organization of patients entering and leaving hospital beds pulls nurses along with it. Scarcity of available beds within a palpable line-up of patients waiting to occupy them creates pressure on nurses. They must respond by getting patients discharged in order to bring their work into a more controllable order. Working along side Nurse Linda (whose activities discharging Ms. Shoulder were described in Chapter One), revealed how Linda's nursing practice is structured by the tightly organized ebb and flow of hospital admission and discharge technologies.

By following the standardized discharge protocol Linda contributes to the efficient running of the ward. Until Ms. Shoulder (among others) physically leaves the hospital, her presence constitutes a constriction in the rolling out (in actuality) of the virtual order of the bed map. If Ms. Shoulder had vomited, if she had fainted and fallen, or if her pain had been recognized as excessive, she would have absorbed additional nursing time and attention. A patient whose stay exceeds the pre-arranged discharge time, effectively "blocks" a bed that is already being counted on for incoming patients even though it is still legitimately occupied. Disrupting "predictable" discharges requires a nurse to assert herself and advocate for a patient, (i.e. Ms. Shoulder). However, owing to the systematic

process of admission and discharge, in this process of advocating she is not only disadvantaging another patient (i.e. Ms. Leg Wound), but she is also creating troubles for the front-line-nurse-leader, the surgeon, the operating room staff, the bed utilization clerk, the nurse administrators and so forth.

In this particular instance, the nursing work Linda and I were engaged in was circumscribed and restricted by hospital management technologies oriented to optimizing "bed utilization". We adapted our nursing practice, and even disrupted what could be judged as an adequate standard of care for Ms. Shoulder, subordinated as we were within the ruling relation of efficient bed utilization. Linda and I (and Ms. Shoulder too) were caught up in the goings on of the busy hospital setting. In spite of my own unease about Ms. Shoulder's comfort and Linda's apparent concern about her nausea, all three of us implicitly accepted that Ms. Shoulder was well enough to go home; that an extension of her stay in hospital could not be justified. Linda and I were participating in an efficiency strategy. Together, we produced the form and timing of the required discharge.

Linda and I were working within a framework through which we could uncritically bend and fold our interests in effectively nursing this patient through her nausea *into* our knowledge about our professional responsibilities related to rationing resources. In the next section I explore in more detail how nurses' knowledgeable nursing care is disrupted by an organization of the hospital routine that does not allow for nurses' individualized practice with individualized patients. That is, it subordinates nursing knowledge to managerial knowledge priorities.

An instance of efficient bed utilization.

In the following interview a nurse describes her work of discharging an elderly male patient. The patient she is discussing had undergone a major surgery – radical retropubic prostatectomy, for cancer. The nurse explained to me how she had looked after this patient earlier in his hospitalization, during a night shift. At the end of that shift she had assessed and reported the patient as mildly confused and combative. Returning from her days off, she discovers it is "day seven" of this patient's hospitalization – the planned discharge date:

> Anyway, I come back to work and according to all the paper work it's day seven and he's ready to go home. So you wait for his wife to come in, because you know she is going to have her hands full and you need to explain to her what to watch for.

The nurse's professional knowledge and experience informs her practice with this patient and his wife. She recognizes that even though he is "ready to go home" he is still recovering and will require substantial nursing assistance from his wife.

The nurse would want to explain things to this elderly couple about pain management, about how to look after the surgical incision, about the need to avoid straining during a bowel movement and give instructions to avoid heavy lifting. She might also explain about the not uncommon experience of postoperative urinary incontinence and teach the patient how to perform perineal exercises. She continues her story explaining:

> His wife arrives and I introduce myself and I'm trying to figure out who she has already talked to, and I'm trying to slow down so that I can give her all this information in a way so that she won't be too overwhelmed. I am rushing though – through the discharge instructions, the prescriptions, his bowel meds and stuff. So I'm talking to her, explaining about his incontinence and telling her where she can buy Attends (adult diapers).

It is apparent from this excerpt that the nurse's time is a limited resource. The nurse describes how she was aware she was "rushing" – to find out what the patient's wife has been told by other nurses and the surgeon. This is part of her prioritization work – to discover what still needs to be explained. The nurse reminds herself to "slow down" because the wife is overwhelmed. As the discharge session progresses the nurse explains how, despite her teaching interventions, the patient's wife conveys serious concerns about her ability to cope with the care of her ill husband. About the patient's wife, the nurse says:

> She gets all welled up and tells me that he has been hard for her manage at home even before his surgery, and she starts to talk to me about how he's been....and even though home support has been put in, she's still in over her head.

The nurse has assessed that this patient's wife is "in over her head" however, the nurse's options of what she can do are limited. She is working in a situation organized by managerial, not clinical interests. This affects this nurses' own thinking. Her knowledge about the organizational need to accomplish this discharge overrules other nursing judgments as she says:

> But it's already too late you see. The bed's already booked, we are already looking for beds for five same-days (patients admitted that morning and currently undergoing surgery) and so far we only have two, this old guy and one other, so already we're three short. And you know the pressure is on.

The pressure this nurse is under to accomplish this discharge is evident in her knowledge about the "line-up" of patients waiting to occupy her elderly patient's bed. Five beds are needed; so far, two beds have been identified as available, even though at least one of the "available" beds is still occupied. On this day, like many others, there is a serious negative balance of beds for patients who are already admitted and undergoing surgery.

To disrupt the discharge of this confused elderly patient would create significant problems for the organization.

For this nurse, who I henceforth refer to as "Nurse Rushing", a social organization external to her work setting influences her thinking and her approach to this patient. Whatever interventions Nurse Rushing's professional education and experience may direct, her talk reveals how her actions are organized by "bed pressures" as the institutional agenda for discharge intervenes. She explains how she responds to these pressures:

> So you talk to the Team Leader to see if you can get more home follow-up on this guy, but he's got to go, it's day seven. I mean there's just no way. I can't hang on to him because his wife got teary. So I mean, you just kinda kindly bundle them out the door and keep your fingers crossed that home care will catch up with them and then you start looking after the next one. And let's face it, it might feel like hell, but that's not our job, I mean, it might not look like it's very caring, but it's just not efficient use of resources to hang onto this patient for another night just because his wife is having trouble coping. There are all those other patients waiting for surgeries to think about.

The practical problems related to holding this nurse's work site together are evident in this interview excerpt. Despite the fact that "according to all the paper work" this patient is ready for discharge, the nurse identifies patient issues that do not show up in the paper work. As with Nurse Linda's work with Ms. Shoulder, this nurse is faced with developing an ad hoc plan. In this case, advice to stop at the drug store on the way home to purchase adult diapers is accompanied by an attempt to organize more home support.

This data about a nurse discharging a patient is analytically useful to display a nurses' organizational consciousness (Smith 1990b). Smith discusses how:

> Progressively over the last hundred years a system of organizational consciousness has been produced, constructing 'knowledge, judgement and will' in a textual mode and transposing what were formerly individual judgements hunches, guesses, and so on, into formulae for analyzing data or making assessments. Such practices render organizational judgement, feedback, information, or coordination into objectified textual rather than subjective processes (p. 213-214).

In this situation, this nurses' organizational consciousness relates to her knowledge about efficient use of beds and her professional role in reformed hospital settings. It is a bureaucratic product of hospital waitlists and other managerial processes such as the ALC designations, clinical pathways and bed utilization technologies. Her practice is being organized in a way that she "knows" it through the lens of the cost-orientation of "efficient use of resources".

Nurses are organized to compress caring into smaller spaces while learning how to download costs for supplies and equipment into the home sphere and to make use of family members as surrogate nurses. Nurse Rushing, working with an elderly couple who face multiple challenges related to cancer, surgery, incontinence, cognitive changes and so forth, explained how she "just kinda kindly bundled them out the door". She relies on the somewhat tenuous plans for home care, trusting that something has been organized ("keeping her fingers crossed"). She is able to justify her nursing practice through her knowledge about "efficient use of resources" that assists her to understand and make sense of her work.

The contradictions this nurse is dealing with are evident when she expresses how her work "might feel like hell" and how it "might not look very caring". Her description of

her practice reveals a "moment of recognition that something chafes" (Campbell and Gregor, 2002, p. 48). It is exactly moments such as these– in the everyday/everynight practices of front-line nurses – that strategies of reform must subordinate. Nurses' organizational consciousness must be developed in order to ensure an *organizationally correct* course of action. In restructured hospitals nurses must be knowledgeable actors in the "efficient use of resources". Nurses must learn about how diverting a discharge to address a wife's tears and concerns is *not* their job. Nurses' job is to think about "all those other patients waiting for surgery".

Nurse Rushing responds, as she must, to an organized and systematic process for moving patients into, through and out of the hospital. The "paperwork" she references is a critical pathway (see Chapter Two) that establishes the correct discharge schedule. Bed utilization depends upon nurses accepting the primacy of the discharge. Nurse Rushing's account contains traces of a distinct set of generalizing relations that organize how her nursing practice is produced. She is subject to compelling enforcement strategies that coordinate her business-oriented thinking and her practices with patients. Despite evidence that both Nurse Linda and Nurse Rushing knew their patients would benefit from more nursing care, their response was to subordinate their professional impulse and respond instead to a more compelling principle. "According to all the paper-work" these patients met predefined criteria for discharge. This is the moment when managerial knowledge and authority overwhelms a nurse's professional training about adequate nursing intervention. In the next section I examine more closely how managerial knowledge, with its built in dominance of cost-relevance, is being methodically inserted

into nurses' everyday/everynight activities to enforce the efficiencies of restructuring into nurses' thinking and actions.

Nurses' knowledge is actively supplanted

Alternate Level of Care[29]

Nurses' "clinical" thinking is supplanted by "cost-oriented" thinking through managerial technologies that go far beyond the physical organization of bed scarcity and patients waiting. ALC is one method through which nurses develop an organizational consciousness about cost-oriented "efficient use of resources". In the instance of Nurse Rushing, she was fully aware of the efficiency mandate she was accomplishing. This is not always the case. In many instances, the managerial technologies being introduced into nurses' practice work so effectively that nurses lose sight of the cost-orientation and efficiency practices permeating their work. Alternate Level of Care (ALC) is an important instance of how a health information technology unconsciously dominates nurses' thinking and imposes its "efficiency" regime.

In the hospital where I observed ALC activities, the textual work of inserting ALC practices into clinical practice was (managerially organized) to be initiated by nurses in direct care. Nurses activated the ALC designation process by making a note on the "doctor's board". The doctors' board is a bed map of the ward listing the names, diagnosis and location of each of the patients who are currently occupying beds.[30] It is attached to a clipboard, which is located at the main desk on the nursing unit. Nurses use the doctor's board to make notations related to concerns they have which require a physician's attention. The physicians and surgeons look at the board during their visits to

the nursing unit. The nurses' notations on the board prompt the physicians to attend to the nurses' comments and requests. In the case of ALC, the nurses' comments prompt the physicians to consider whether or not a particular patient should be classified "alternate level of care". On the board it usually appears as the cryptic notation "? ALC". Frequently the nurse in charge will also affix the formal ALC designation form to the doctor's board to conveniently acquire the necessary doctor's signature. Once the patient has been officially designated ALC and the bureaucratic processes have been put into place (see Chapter Three), the patient becomes "flagged" as ALC on all of the worksheets nurses use to organize their care.

My observations of nurses' front-line practice showed how the ALC designation, inscribed onto nurses' worksheets was being used as a "diagnostic" term. Nurses use worksheets (Appendix F) in their practice as quick references to assist them in organizing the care for the group of patients to whom they have been assigned. Along with the patient's medical diagnosis, these quick reference tools usually include information about a patient's diet, intravenous solutions, and other pertinent facts about current conditions or requirements for care. It was on their nursing worksheets that I observed nurses using the ALC designation as a medical diagnosis. In the same way a nurse might say "this patient has diabetes", I overheard nurses saying, "this patient is ALC". The first time I encountered ALC on a nursing document I had to ask for clarification. The way it appeared under the diagnosis column of the worksheet I assumed it was an abbreviation such as ALS (amyotrophic lateral sclerosis) or CHF (congestive heart failure). I was told

that ALC stood for alternate level of care. Further inquiry elicited the response "it means they really shouldn't be here".

The ALC terminology and framework is methodically inserted into nursing activities. I began to see nurses' coaching in ALC use as the development of an organizational consciousness that subordinates other ways of thinking about and organizing the care of frail elderly people. Training in the use of the ALC designation is offered to all nursing staff and managers who are involved in its use. For instance, the bulletin I observed (and discussed in Chapter Three, p. 112) titled "Understanding Alternate Level of Care" (May 28th 1997 CIHI), posted in a nursing unit, is a strategy to teach nurses about how they are to take up ALC. This document summarized an "ALC Information Session held in April of 1997" and related how:

> Twenty-three participants representing utilization management, admitting, health records, social services, financial planning and nursing were in attendance. The attached document is a summary of the questions[31] discussed at this session" (CIHI, May 28th 1997, p. 1).

Nurses take what they know about ALC designation (what they have learned from CIHI) and actively work to apply this (conceptualized) representation of a "case type" to patients in their care.

Pragmatically, the ALC designation directs the work nurses are required to do for the patients in their care. Policies have been written for ALC designated patients that reduce the minimal required standard for nurses' record keeping. Also patients who have been designated ALC are not required to have their blood pressure, temperature and pulse

monitored. This formal work reduction associated with an ALC designated patient produces an incentive for nurses-in-direct-practice not only to formally identify ALC patients but also to discover which patients in their care have been given the ALC designation. Institutionally vetted ALC policies offer nurses a modicum of control over the sped-up pace of their work setting where they are constantly trying to squeeze the required standard of care into smaller and smaller spaces.

Nurses are organized to unproblematically insert ALC into their professional conceptualization of their work with patients. When registered nurses were interviewed about how they work with people whose diagnosis appears as ALC in their worksheets, their talk was infiltrated with traces of gerontology as a specialized body of nursing knowledge: For instance one nurse told me:

> I find having a lot of ALC's can be difficult. They have different needs than the acute patients. They often take a lot of time because they are old and most of them are really dependent. I mean, that's why they can't go home because they need all this help. We should be working towards keeping them as independent as possible, but that takes time.

Even though ALC is oriented to a cost-cutting strategy, nurses activate the ALC diagnosis through their own "traditional" knowledge of gerontology. When nurses encounter their patients' ALC designation they categorize them as either "acute" or "ALC". Then, as the next data excerpt shows, the category becomes "active", influencing the nursing care that is carried out.

> I do use a different mindset with these people (ALC designated patients). There's not a lot we can do for them here. Sometimes they stay for weeks and you can just watch them slipping away. They lose their confidence, we watch them getting increasingly withdrawn. I try to make sure the ALC's get up in the chair and have some sort of

> stimulation, I mean we should be dressing them and everything, but it's difficult. We're just not set up for that sort of thing in acute care. They really shouldn't be here. When I am busy, they are the ones that have to wait.

Despite nurses' knowledge about the time-intensive, skilled work required to respond to the unique personal needs of frail elderly people, the data excerpt demonstrates how this nurse references the bureaucratic ALC criteria as the basis for determining who is and who is not appropriately treatable. This nurses' knowledge about the care required by gerontological patients is subjugated to her new knowledge about time and efficiencies. She describes how she has adopted a "different mindset with these people" explaining, "when I am busy, they are the ones that have to wait". Nurses' knowledge about business-like rationing practices to do with who is an "appropriate" versus an "inappropriate" recipient of hospital resources is displayed when this nurse explains, "they really shouldn't be here". It is comments like this that indicate how, unwittingly, nurses have adopted cost-relevancy as a way of understanding their patients needs.

ALC is referenced on nurses' worksheets and nurses are actively coached about how ALC operates. Nurses' expectations that patients in acute care get better and move on, and their awareness that hospitals are places where only certain categories of illnesses are nursed, are secured through the insertion of the ALC category into their work processes. ALC promotes, in nurses, the managerial view that patients must move out of hospital beds quickly. It effectively inserts rationing practices into the clinical judgements of hospital nurses. This business-like knowledge (appropriate vs. inappropriate patients; important vs. less important needs; deserving vs. undeserving candidates for care) enters into how nurses make decisions about who gets attention, who can wait, and who must be

sent home. Comments from a number of nurses reflect the low priority of ALC patients when they plan and order the care of their assigned patients:

> "Often they just have to wait".
>
> "They're not as sick as the other patients and if I have to decide I have to look after the sick ones first".
>
> "They're the stable ones".
>
> "I focus on the assessments and treatments of the acute patients first".

Methodically inserted into the local sites of nursing practice ALC becomes integral to a new "business-like" nursing knowledge, used by nurses to justify difficult decisions about who is appropriate, who "deserves" the finite resource of nurses' time.

My interview data reveal that nurses' work with ALC patients is complex. It frequently reflects comments about the *extra time* long term, stable, but physically dependent patients require. Various nurses commented:

> "They're slow".
>
> "They're often confused".
>
> "Sometimes they are combative".
>
> "They are heavy physically".
>
> "They take a long time to feed".
>
> "They have a hard time swallowing their pills".
>
> "Many of them are incontinent or require frequent toileting".
>
> "You know you can't rush these folks"

Nonetheless, this "hands-on" knowledge about the skilled and delicate acts of caring for frail, cognitively and physically disabled elders is dominated by the textual representation of ALC designated patients as inappropriate recipients of care.

Nurses have learned that ALC patients must fall to the bottom of a nurse's priority within the limited resource of their time. Nurses come to understand (to know) that these patients "really shouldn't be here". Nurses are coached to develop ways of thinking that subordinates other ways of thinking about and organizing the care of frail elderly people. When a patient's needs for nursing actually prevent them from being moved out of the hospital in a timely manner, they become a candidate for the ALC designation. Nurses have learned how the ALC category represents inefficiencies. Patients who fall into this category take on the individual characteristics of being inappropriate contestants for rationed nursing labour resources. Thus nurses know how to operate within a hierarchy of legitimacy for health care that is constituted through the *particular* business-like knowledge generated through health information technologies. The use of ALC as a diagnostic term marks a distinct change from patient diagnosis based in traditional medical or nursing science. Nonetheless, when nurses take up ALC as a "diagnosis" *it organizes and influences nurses' thinking and actions.*

Nurses' cost-oriented thinking is enforced

Care Maps and Clinical Pathways

Care maps and clinical pathways are standardizing texts inserted into the routine practices of nurses. They systematically insert the relevance of "counting" and "benchmark targets" into the everyday/everynight activities of nurses-in-direct-practice. Patients with cardiac illness, patients undergoing surgeries, and even patients experiencing mental health illness are grouped and categorized to determine "optimum" (efficient) lengths of hospital stay that can be defended as evidence based and quality assured.[32] Based on this "medico-administrative" data (Mykhalovskiy, 2001), discharge targets are developed and

strategies are employed to organize and focus nurses around a planned discharge time and date. These data are used to develop the textual tools nurses are required to use (as part of their routine care-planning), that direct standardized, timed, interdisciplinary interventions throughout a patient's hospitalization. Daily, authoritative knowledge about the primacy of the discharge is superimposed onto nurses' hands-on knowledge. My analysis of the care-map technology explicates some of the "behind the scenes" work being done by managers to introduce and enforce nurses' compliance with the goals of hospital restructuring.

In the interview excerpt quoted earlier in this chapter, Nurse Rushing explained: "Anyway, I come back to work and according to all the paper work it's day seven. . . but it's too late, he's got to go, it's day seven". The fact that this patient is "day-seven" authorizes how this nurse knows how to proceed in this situation. Knowledge about what "day seven" means, dominated what else this nurse knew about this patient – it overruled her own doubts about her discharge activities. Despite the fact that this nurse described how "it might feel like hell" she did not disrupt the discharge. She subordinated her other ways of knowing about how to carry out her nursing work. She rationalized her actions through her knowledge of bed pressures and waiting lists, constructing her understanding about competent nursing practice within the scarcity and rationing practices of contemporary hospital reform.

On one orthopaedic ward where I conducted participant observations the nursing unit manager was charged with developing and implementing two clinical pathways. Minutes

from meetings convened to develop and implement the pathways, and the pathway texts themselves, provide data to explicate the enforcement capacity of these types of textual tools. The clinical pathway discussed here is for a patient undergoing total hip replacement surgery (hip arthroplasty) (Appendix G).

The development and implementation of clinical pathways by the orthopedic unit manager was not directed by any perceived general incompetence in nursing care provided to patients who were undergoing arthroplasty surgery. At this hospital, clinical pathways were initiated because current care practices were judged (by the technologies of counting) to be inefficient as they related to *costs*. The average length of stay for hip and knee surgeries surpassed the provincial average. According to a 1997 ministry report the hospital was: "remiss in employing effective utilization management efforts in order to ensure the residents have reasonable access to health care services" (Regional Hospital, Financial Management & Operational Assessment – Review Team Report, 1997). "Clinical pathways" are a managerial solution to bring local practices in line with a provincial benchmark.

Financial support to develop clinical pathways was provided by "Total Joint Enhancement Program", a "one time only" infusion of funding from the Ministry of Health. The funding was publicly heralded and announced in the local press. According to media reports ministry funding was provided to reduce the lengthy (compared to peer hospitals) local surgical waiting list for arthroplasty surgery. According to documented minutes from a "Total Joint Enhancement Meeting": "Ministry of Health 'transitional

funding' for the program provides additional resources specifically targeted to provide increased OR time, physiotherapy/occupational therapy/nursing hours/*and resources for developing clinical pathways*" (Total Joint Enhancement meeting minutes, italics mine).

Funding for the Joint Enhancement Program was intertwined with a ministry recommendation that the hospital establish a "Care Access Program". This program was to be developed to "enhance timely access to alternative services (ambulatory and community based) in order to either prevent in-patient admissions or reduce length of stay" (Regional Hospital, Financial Management & Operational Assessment – Review Team Report, 1997). The "joint enhancement" initiative was one managerial response to ministry criticism (based on the health information technologies of counting) that this hospital had not established an effective utilization program.

The clinical pathway component of the new Joint Enhancement Program had the effect of constituting nursing work as a management problem to be resolved. If the treatment of patients undergoing arthroplasty surgery was to be sped up, nurses must be directed to work differently from how they had learned in school and how they had honed their skills through experience. The clinical pathway did that. Vested in texts – forms, charts and so forth, it organized nurses and allied health professionals across time and space to ensure that standardized activities happen at a particular time. Managerial requirements for nurses' particular interaction with standardized text-based directives produce a nursing practice that is mediated by textual accounts, accounts that can be audited and "counted" and can stand as adequate nursing if challenged.

Minutes documenting Total Joint Enhancement meetings offer insight into how nurses' work was being organized to work in ways that will result in the outcomes the hospital needs. The minutes show the level of ministry interest in enforcing bed utilization practices to align hospital statistics more closely with provincial benchmarks. They also show the pragmatic concerns of the Total Joint Enhancement group as they strategize ways to mediate and enforce accountability and efficiency practices into the local practices of nurses in direct care. The people at the meeting understand that nurses' "activation" of the clinical pathway text (here called a care-map) is critical to accomplishing a standardized five-day discharge for patients undergoing knee or hip replacement surgery. Minutes of the meeting reflect a discussion about whether or not the care-map could replace existing charting protocols. The minutes read:

> . . . in any case, it was felt that the charting would have to be left as it is but we could use the care map as a *mind-set and objective* for the staff, and as a score card. It was decided that the care map would go into the chart where the relevant discipline, be it Nursing, Physio or OT will circle the item that a patient has not met for that day if appropriate. (Total Joint Enhancement Minutes, italics mine).

In order for the clinical pathway to work effectively to reduce length of patients' stay nurses must *use* the tool in their daily work. They must adopt the treatment schedule established by this care-map. It is intended to adjust nurses' "mind-set". Once nurses adopt the mind-set of timely discharge, nurses themselves can be relied upon to enforce the standardized rationed length of stay. Through the clinical pathway technology nurses are organized to knowledgably take up the standardized goal of the five-day hospitalization as a nursing concern.

Managerial efforts to teach nurses how to insert the new efficiencies into their practices are revealed by plans for "inservice education sessions" for the nurses:

> Inservicing of the staff will be necessary. (Unit Manager) is talking of whistlestop types of inservice plus one large meeting. The staff nurses on (Ward) have already had one staff meeting orienting them to care mapping and this was received positively (Minutes of Total Joint Enhancement).

Nurses are taught how to practice differently. Nursing's new front line leaders (in this hospital the "unit manager")[33] are actively enrolled to orient nurses to the primacy of the discharge. In the case of care mapping, the unit manager, having developed the form, is now involved in "orienting" the nurses to the form in order to ensure its regulatory effects.

That the form is to be used as a "score-card", demonstrates how the tool can be audited and can function as an organizational system of control to direct the practices of nurses. It enforces the textual plan for care. As such it is a constituent of the social relations of restructuring. The people gathered at this meeting make use of the organizational ruling power of texts in contemporary society. They know how to use the "peculiar force" of texts to "transcend the essentially transitory character of social processes and to remain uniform across separate and diverse local settings" (Smith, 1990b, p 211).

One feature of the ruling capacity of clinical pathways is in shifting the agency of nurses' work. A clinical pathway is a documentary process used to authoritatively influence nurses' activities. It directs nurses to "start to generate discharges on admission" (Interview , patient services director) by focusing them on daily "targets" established for

each pre-planned day of hospitalization. The pathway technology also makes certain aspects of nurses' work visible to scrutiny and open to correction.

Not only are nurses oriented to the "standard" trajectory of care. Patients too are oriented to the "expectations" of each hospital day. Nursing activities in the pre-admission clinic are structured around "teaching patients about their hospitalization and orienting them to the daily targets" (Minutes, Total Joint Enhancement), which culminate in the all important discharge target. At the research hospital where these orthopedic clinical pathways were instituted, patients are required to sign a "Responsibility Form" (Appendix H). This form is another enforcement strategy intended to discipline patients to the required discharge arrangements prior to entering the hospital. According to a nurse from the pre-admission clinic, patients are told that if they do not acquire the raised toilet seat, their surgery will be cancelled. Patients and informal caregivers are expected to incur the costs related to moving patients out of the hospital quickly. The clinical pathway becomes the ground around which all the nurses involved in the patient care, and the patients themselves, are organized.

From a managerial perspective it is not sufficient to rely on the clinical expertise of professional caregivers to organize what and when things get done. A patient services director I interviewed remarked how

> It (the care-map) achieved the coordination of all the team members so that each person knows what needs to be done and when . . . it means you don't have to wait around to get an order to get patients going. Nurses can start to generate discharges on admission.

The pathway tool provides a means of managerial control over work that, previously, was regulated professionally. According to the manager, the tool organizes the multidisciplinary team to know "what needs to be done and when".

One year following the implementation of the clinical pathways I talked to the nursing unit manager who led the clinical pathways project. She expressed frustration that the pathways were not being fully implemented. Resources to audit a patient's progression through the clinical pathways were not available when the Total Joint Enhancement Funding ran out.[34] Nonetheless, this unit manager noted that since the implementation of clinical pathways "the ward has been much more consistent with our five day discharges". At this hospital, the pathways themselves, nested in a set of authorized standard doctor's orders and ongoing coaching and mentoring has accomplished the discharge targets. Despite lack of monitoring for "variance", the daily practices of doctors and nurses is changed and the managerial agenda of a five-day discharge for knee and hip arthroplasty has been successfully accomplished.

Managerial technologies such as the clinical pathways being described here are designed to govern (for cost relevance) what nurses *know* about their patients and the interventions they require on each day of the hospitalization. In other settings, such as in Post Anesthetic Recovery (PAR), pathways have been developed that divide the patient's stay into half hour intervals such as "admission to 30 minutes" (Windle, 1994 p. 80F). Instructions for the minute-to-minute nursing interventions in the PAR pathway direct timed assessments (checking vital signs) and standardized, timed interventions

(application of warm blankets and oxygen and instruction related to patient controlled analgesia), and direct strict record keeping "document immediately" (Windle, 1994, p. 81f).

It might appear that the efficiency interests of a health care organization share common ground with the interests of individual nurses and patients. Clearly there are important points of coincidence of interests. It is my concern, however, that through the managerial technology of care mapping, combined with the technical controls organizing how patients enter and leave nurses' practice, the interests of restructuring (for cost efficiencies) are organized to supersede autonomous, expert, individualized nursing judgment. Tools such as the care-maps, ADT systems and ALC protocols build and enforce directions for efficiency into nurses' discretionary work. They construct the taken-for-granted knowledge Nurse Rushing used when she interpreted how "according to all the paper work it's day seven" and how although "it may not seem very caring" she knew (had learned) that it is more important to be attentive to "efficient use of resources". The technologies succeed in placing the needs of individual patients in an oppositional relationship with the authoritative relevances/priorities of hospital management.

The primacy of the discharge

Technologies to enforce cost-reductions into the practices of nurses and physicians extend across all contemporary Canadian health care settings. Permutations of clinical pathways were active in all the BC hospitals I investigated. One hospital developed a "discharge-planning manual" which detailed roles of charge nurses, ward clerks, admitting nurses, social workers and physicians as they relate to the discharge. At this

hospital very detailed criteria have been developed to "score" whether or not a patient should be admitted to hospital and likewise to identify patients who must be discharged. Known as the PROMPT™ system, it directs nurses to scan patient records using broad categories such as "tubes" "respiratory therapy needs", and "monitoring activities". Such systems for standardizing discharge decisions provide the possibility for more scrutiny of nurses and physicians judgement about who is "well enough" to be discharged. Previously discharging patients was a matter of clinical judgement. Now its objective/textual nature makes it a matter open to managerial control.

Another research hospital maintained a system known as a MCAP™, a computerized system of auditing information written on patients' charts against predetermined criteria. Using MCAP™, systematic chart audits are conducted on admission and randomly throughout the hospitalization to determine whether or not the patient should have been admitted, and whether or not the patient continues to meet admission criteria. At this hospital, nurses (who use to be called "discharge planning" nurses but are now referred to as "utilization nurses") spend their days auditing charts and inputting data into computers for MCAP™ analysis. Patients who do not meet the criteria are designated "off index". "Off index days" are calculated monthly and announced regularly at meetings where physicians and Nursing Unit Managers are held publicly accountable for their "off index" days. This level of scrutiny acts as an enforcement of the utilization agenda.

At the large metropolitan hospital where my family member was admitted following her head injury, bed utilization practices are highly systematized. Physician's discharge

practices are tightly controlled through a broad based system of computerized patient records. Criteria for patient admission are tracked by physician's daily entries on patient records. Based on this record keeping work, "off index" patients are immediately flagged. When this occurs, family are summoned and patients are summarily discharged. My aunt Hannah was discharged one afternoon with no forewarning. On the day of discharge I had been at the hospital very early in the morning to speak with the neurosurgeon who was Hannah's primary physician. At this time there was no mention of an imminent discharge – Hannah continued to experience significant speech impairment from her head injury and was undergoing active speech therapy. Severe headaches were an ongoing concern as were her difficulties passing urine. Later that afternoon I drove through rush hour traffic to my sister's suburban home to discover that a nurse from the hospital had called to inform us that Hannah had been discharged! Presumably her current needs no longer met the criteria for hospitalization. She had been identified as a candidate who could be discharged into the care of family.

Chapter five conclusion

Hospital restructuring has accomplished a major change at the site of direct nursing practice. Clinical pathways, ALC, PROMPT, MCAP™ and patient satisfaction technologies are systematized institutional technologies actively enforcing nurses' cost-orientation into their judgements about patients. The systems that are being used to imprint business-like efficiencies at the site of nursing practice are highly sophisticated and have been extensively discussed in the nursing and health management literature (see Chapter Two). That these technologies are a major source of nurses' troubles is less well understood. Across sites of practice nurses adopt an organizational consciousness that

generates efficiencies as a ruling relation. Nurses adopt a business-like nursing practice that privileges managerial knowledge over "traditional" nursing knowledge. Nurses' new knowledge – about levels of care, about patient satisfaction, about criteria for hospitalization and so forth – generates "improvements" in bed utilization. Accounts of all this are used to reassure a worried public about the adequacy of Canadian health care. However, the stories of the NUC group with whom I was associated and my own experience during Hannah's hospitalization tell a very different story about how patient care may be seriously jeopardized in restructured hospitals.

The health information technologies and the strategies they inform cannot be ignored; even highly competent, principled nurses are captured by the enforcement technologies that produce screening and rationing activities and that subordinate individualized professional interactions. The technologies, introduced into the direct sites of nurses' practice, produce the physical pressures of a bed scarcity. They are inserted into nurses' documentary practices to discipline nurses to the standard practices. Overall the technologies sway and dominate nurses' professional (clinical) discretion. Nurses' knowledge about *how* to produce a proficient nursing practice is moulded to conform to the business-like strategies of modern management.

However, not all nurses have completely adopted the cost-orientation efficiencies. While all nurses feel the pressures and demands of the bed scarcity, they cannot all be relied upon to focus their work on the smooth rolling out of efficient admissions and discharges. Many nurses are left with the chafing knowledge that something has gone terribly awry in

contemporary nursing practices. And while their explanations lack the detailed analysis my research produces, these nurses are critical of what they see happening around them. Many nurses continue to view the new documentary practices related to clinical pathways and flow sheets as unnecessary incursions in their workaday practices. They resist what they see as "form-filling work". One nurse described how she had launched a "boycott of the computers". She said, "even though I know we're supposed to use the computers for all the lab and diet orders, I still do it the old way". Another nurse said "they are trying to get us to only change the linens that 'really need it', as far as I am concerned, any patient who spends the bulk of their time in bed really need their linen changed everyday". Other nurses are simply not able to keep up with the demands of the sped-up work place. A novice nurse I interviewed described how even though she knew that she should have completed a "patient transfer form" to hasten a patient's transfer, she simply did not have time to attend to this work. These small acts of resistance and/or lack of aptitude produce troubles in the workplace. They become something else to be managed. In the next chapter I outline how the work of head nurses is being restructured to address recalcitrance or ineptitude of nurses who are being organized to work with the new efficiencies.

Chapter Six

Front-line-nurse-leaders at the line of fault: Reorienting clinical leadership

Introduction

To enforce a business-orientation in nursing activities a corps of nurses with a well-established managerial perspective is needed to direct and monitor nurses' work. In this chapter I analyze the reformed work of head nurses in restructured hospitals. I explicate how a changing conception of "clinical leadership" and new responsibilities for rationing resources require head nurses to alter their primary concerns as clinicians, teachers and coordinators of care. I argue that this is another "level" of enforcement activity. Nurses in direct practice are organized to alter their individual practices with patients. Head nurses' are organized to alter their individual practices with staff. Head nurses are strategically positioned to enforce efficiency practices into the activities of both nurses and doctors working on their nursing units. Head nurses' accountability to the new management technologies has been added to the leadership and supervisory skills of an earlier era. There is a market-like competitiveness imposed on head nurses' work that aligns them more effectively to the efficiencies they are expected to generate. They are taught/have learned knowledgeable ways of thinking and acting that subordinate "pre-reform" nursing interests. Head nurses' mastery of their new responsibilities is an essential feature in developing the efficiency practices of staff nurses. I describe how, at the front-line of nursing work, head nurses too, have developed a distinctive organizational consciousness that is essential to aligning nurses' knowledgeable practices with the business-oriented goals of reform.

Head nurses hold a key position in relation to the managerial technologies being implemented into nurses' work. In the previous chapter I displayed some of the intricacies of clinical pathways describing how the pathways work as a managerial strategy to contain costs. The pathways were made a mandatory part of nurses' documentation activities, and nurses were coached in their use. I observed how the head nurse on the orthopedic ward where the pathways were introduced was instrumental in the development and implementation of clinical pathways. These texts, when they were properly used, mediated nurses' actions. The head nurse was responsible for nurses' adherence to their use. Similarly, with the ALC initiative I analyzed, the head nurse was largely responsible for its implementation on the ward. During the introduction of ALC, the head nurse told me that she had attended a meeting with the hospital's director of medical records where she herself learned about the designation. She was given an ALC information bulletin and asked to post it in the nurses' station. During an interview she told me:

> It is important that we get a handle on the types of patients who are taking up these beds. We really need to start asking, "do these people really need to be here"? In report, when it is apparent a patient has stalled, I'll ask the nurses if any of these patients can be made ALC. I prompt the docs too.

This head nurse was given the responsibility for teaching others about the ALC designations. The technology became part of her everyday work with doctors and nurses. Both in the care-map and the ALC initiative, head nurses played a pivotal role in how managerial technologies were brought into play.

In the pre-reform model a head nurse was generally a seasoned nurse, clinically proficient in her ward specialty. Head nurses' work focused on clinical goings on. They listened to shift report. Head nurses interrogated nurses about patients' progress. They frequently did "rounds", meeting and interacting with patients in order to have a current knowledge about patients' conditions. They monitored individual nursing practice, mentoring and disciplining, as they deemed necessary. A head nurse was a resource for staff, a person who could (professionally) supervise and guide staff-nurse practice. Head nurses coordinated staff-nurses' workload, they decided which beds patients would be admitted into. The head nurse was a pivotal point in the communication with doctors, updating them on patient's conditions and acting as liaison between the nurses working on the floor, and physicians who are frequently only available by phone. Some of the traditional work of head nurses still happens, and some of her physical movements around the ward, on the surface, appear unchanged. However there is a distinctly different orientation to the work she is accomplishing. What this chapter illustrates is how the reformed work of head nurses inserts a managerial (rather than a clinical) framework for overseeing nurses and nursing work right at the site of clinical nursing practice.

Restructuring head nurses' jobs and titles

Throughout the years of reform and hospital restructuring, the job descriptions, titles, roles and responsibilities of head nurses have been undergoing much scrutiny and change. Across hospital sites, the title and model of the head nurse position is diverse. Head nurses are no longer called "head nurses" they hold a variety of titles such as "Nursing Unit Managers", "Care Coordinators", "Team Leaders", "Program Managers", "Clinical Coordinators" and "Nurse Clinicians".[35] For the purposes of this research I

refer generically to nurses who hold positions akin to the old head nurse job as "front-line-nurse-leaders".

Restructuring the work of nurses in front-line-leadership is an evolving process. The tertiary hospital where my aunt Hannah was admitted, following her fall down the stairs, is a large, trend setting hospital for British Columbia. At this hospital the role of the front-line-nurse-leader has been deleted entirely. Staff nurses rotate, shift by shift, as "charge nurse".[36] "Clinical practice unit managers" (not necessarily nurses) are appointed to out of contract (union excluded) positions. They hold responsibility for managing "patient care in a number of different disciplines" (CPU manager job description). They occupy offices geographically removed from the central nursing unit (now called a clinical practice unit (CPU)). CPUs are organized within an explicitly corporate structure of "hospital business units" (1999, (The) Hospital organizational chart).

Unlike the work of staff nurses, whose job descriptions and work processes are assumed to be unchanged by restructuring strategies, the position and responsibilities of the nurses in front-line-leadership are *formally* changed as hospitals restructure. During the past decade, in one hospital where I conducted participant observations, the front-line-nurse-leader role has undergone three major reviews with ensuing changes in the title, credentialing requirements, and job description. At this hospital the front-line-nurse-leader position has remained within the BC nurses union contract.[37] Each of the changes in title and job description occurred within a larger reorganization of the hospital

management structure. Most recently the role and responsibilities of the front-line-nurse-leader was reorganized as the hospital moved to an organizational structure known as "integrated programs".

The new job descriptions for front-line-nurse-leaders have responsibility for the managerial technologies referenced in them. During the initial switch from head nurse to clinical coordinator the job description detailed how: "Under the direction of the Patient Care Manager, the Clinical Coordinator plans, organizes, coordinates, participates in and evaluates care delivery and supervises and evaluates staff on assigned unit" (CC Job Description, 1994). That new role was to include:

> Coordinating and ensuring the delivery of quality patient care; establishing nursing care procedures; communicating standards to staff; developing and implementing effective nursing care routines; assessing workload and allocating staff accordingly; ensuring effective discharge planning; identifying utilization issues; overseeing team conferences and unit staff meetings; liaising with the multidisciplinary team; carrying out quality assurance activities and projects; and advising the Patient Care Manager of ongoing deficiencies in the systems, services and resources that support patient care (CC job description, 1994).

A colloquial reading of this job description sustains the "clinical" interests of nurses as they relate to a "standard of care". The job description is written in such a way that the health information technologies to which the work is geared are not immediately apparent. The job description could be describing the pre-reform head nurse model where the veteran, clinically proficient nurse relied on her knowledge and experience to ensure that the nursing routines resulted in good nursing care, that nurses work assignments were manageable and that members of the multidisciplinary team communicated effectively with one another. This is not the case. Buried in this job

description are the managerial technologies to which the front-line-nurse-leader is to be accountable. As I have been showing, establishing effective nursing care *routines*, ensuring *effective discharge planning*, assessing work-load,[38] identifying *utilization issues* and carrying on *quality assurance activities* and projects – are all irrevocably linked to the business techniques of counting and comparing, classifying and categorizing and evaluating and accounting explicated in Chapter Four. This job description inserts a new (text-based) accountability structure into the work of front-line-nurse-leaders.

A patient services manager described the evolution of the front-line-nurse-leader role (the team leader) as it has been developed to enforce hospital efficiencies. She was talking about hospital bed utilization when she said:

> We are developing the team leader role in that direction now. They are doing a lot better at it this year than they were last year. In fact, two of the new team leaders are actually the displaced utilization reviewers, so in that respect, they are already very much on board with utilization, but now they are in a position where they are actually able to coordinate it with patients.

The revised job descriptions of front-line-nurse-leaders are part of a broad strategy to improve hospital bed utilization. The director quoted above revealed how team leaders are crucial to the efficiencies sought at this hospital. She comments on how the team leaders are "doing a lot better at it this year than they were last year". She continues:

> Team leaders are responsible for discharge planning so they have a pivotal role in coordinating all the things around discharge planning. Figuring out the family picture, the available services. Of course they have staff feeding into that. But they coordinate it all, the social workers, the long term care assessors, continuing care. They are supposed to monitor their own bed utilization.

The new focus of front-line-nurse-leaders work is "coordinating all the things around discharge planning" that will facilitate a speedy movement of a patient out of the hospital. "The family picture" suggests a new interest by hospital nurses in what family members are available to take on nursing responsibilities at home. The team leader is also to understand the services that are available in the community. She is expected to organize her staff to "feed into" the development of a comprehensive knowledge about the patient's family, financial circumstances, living situation and so forth. Managerial interests in bed utilization are devolved to the front-line-nurse-leaders. Front-line-nurse-leaders are responsible for efficiently coordinating discharge work so that "improvements" can be tracked in utilization statistics front-line-nurse-leaders are required to monitor.

Front-line-nurse-leaders guide nurses' cost-oriented work

Front-line-nurse-leaders are active in directing nurses' work with patients in line with the cost-dominance that orients their new roles and responsibilities. For example, during participant observation conducted during the nurses' change of shift report the front-line-leader stopped the audiotape three times to interject. All three interjections were directed to her staff to ensure appropriate discharge work would be accomplished with particular patients. The front-line leader made a point of bringing the nurses' attention to the special teaching required for patients being discharged who must learn to self-administer anticoagulant injections. In an aside to me she mentioned:

> The new staff need to remember to teach the patients how to do it or else they have to stay an extra day or else we have to send homecare in.

Whereas in the past, this form of 'reminder' was used to assist nurses to develop their expertise within particular practice settings, it now has a very different aim. Here, utilization issues dominate nursing plans. If patients have not mastered the injection technique they may require an extra (wasteful) night in the hospital. Homecare nurses may be called upon to visit the patients at home and administer the injections, but the most cost-effective measure is for patients to learn to give the injections themselves. Teaching a patient (or a patient's family) how to administer an injection is a time consuming process that takes nurses away from the other care post-operative patients require. It is the front-line-nurse-leader's responsibility to ensure that this bed generating activity is prioritized within the nurses' plan of care. The reminder to nurses to attend to teaching patients how to give themselves injections is just one of the myriad tasks that contribute to how nurses in direct practice and front-line-nurse-leaders are being organized to "feed into" the organizational imperative for discharges.

Front-line-nurse-leaders' restructured work focuses attention on patients and on nursing work as units of resource expenditure. Front-line-nurse-leaders are responsible for controlling and rationing disbursement of scarce resources. Nursing labour is a valuable and scarce resource and front-line-nurse-leaders must orient nurses to focus their valuable labour wisely. Besides directing nurses to spend time generating expeditious discharges, front-line-nurse-leaders also attempt to limit nurses' use of time on tasks that seem wasteful or inefficient. I saw that happening at the end of the shift change report. The front-line-nurse-leader became somewhat impatient with the detailed tape-recorded report we were listening to commenting that it was too lengthy and in depth. She told me that

she had been "working with this nurse to reduce the length of her reports". She explained that if she (the front-line-leader) was not able to get out of report until after 8:10 a.m. "I miss the doctors and don't get the discharges".

This comment suggests the changed interest front-line-nurse-leaders have in hearing the verbal reports of nurses who are going off shift. Much of what the nurses have to report is no longer relevant to the new duties of the front-line-nurse-leader. Since I conducted these observations, end of shift report on this ward has been changed to a written format. Nurses no longer give "verbal" reports, instead, they make brief notations on standardized forms that the next nurse reviews prior to starting her care. The team leader explained that the new reporting method was designed to ensure that valuable nursing time is not "wasted" sitting through lengthy (inefficient) reports. At the same time, the new reporting system allows her time to broach the topic of discharging patients with physicians who she noted frequently come in to see their patients early in the morning during the nurses' shift change.

On the face of it, front-line-nurse-leaders continue to be charged with the responsibility for "patient care". Yet, my research explicates that in restructured hospitals, what is termed "clinical leadership" is distinctly managerial and is centred on cost related efficiencies. While conducting participant observations with one team leader, at the beginning of the shift, he methodically reviewed each patient's chart document. As he was working, he explained:

> I do this at the start of every shift so that I can stay on top of what is going on. I need to figure out who might go.

While looking through each document, he made additional notes on his bed map/worksheet. Explaining:

> A big part of my job is getting the families on board early.

Quickly scanning the charts, he commented on each patient:

> "This patient is complex, she has had a CVA (stroke) and a recent MI (heart attack), she has liver metastasis (cancer), she has a husband but there are no supports".
>
> "This is a social admission "Failure to Cope". Penny (social worker) will be ticked off, but if we need a cardiac bed that will be the first one, he really should be designated ALC".
>
> "Her son is in (Small Town), that's important".
>
> "This patient lives alone in (Small Town) he has a son in (Big City)".
>
> "These are difficult ones. The frail elderly fractures. She has a niece who lives in (Big City)".
>
> "This elderly gentleman only has a brother – that does not bode well".

This front-line-nurse-leader is making judgements and decisions about patients. His focus though, is on the scarce bed resource as he works to determine "who might go". His interest in families is related to whether or not they will be able to support the discharge work he is required to accomplish.[39]

To this point in my observation of the front-line-nurse-leader's morning work, I did not discern any "clinical" interest in the actual nursing care required for a patient suffering a stroke, a heart attack and cancer, or the experiences of elderly brothers coping with an unexpected hospitalization. Bed maps, bed status reports and patient's admission records (an administrative form completed by an admitting clerk) are the tools he is using to "get

on top of what is going on" on his nursing unit. This textual work is conducted using text-based records and forms. His work is distinctly administrative as he focuses on patients as units of resource utilization.

As this team leader reviewed the chart of the patient identified as "failure to cope" he paused to point out the "Discharge Planning Flow Sheet". He noted affirmatively:

> That's good, the sheet has been done. That is one of the things I am really trying to work on with the nurses. It gets the referral process moving quickly.

The discharge planning flow sheet is yet another tool used to "save time". It is a protocol developed to authorize "automatic referral" to a variety of allied health disciplines and programs according to pre-determined criteria. For example, on admission, a patient identified as "indigent or transient" would warrant an automatic referral to a social worker; similarly, a patient over 65 who lives alone or with a frail caregiver. The discharge planning flow sheet is intended to build time saving efficiencies into the "social" work necessary to move patients out of the hospital, as did the standardized approach to "clinical" work accomplished by using care-maps, discussed earlier. It is the team leader's job to direct nurses' labour (time) towards the text-based work of completing the discharge planning flow sheet.

Analysis of the development and implementation of the discharge planning flow sheet is useful to explicate how front-line-nurse-leaders are oriented both to patients and to nurses as units of resource utilization and expenditure. During an interview, the team leader whose work I have been describing explained his involvement in developing and

implementing the flow sheet. He showed me the file he had organized for his flow sheet materials. The file contained minutes from a meeting of team leaders and Patient Care Directors of the acute wing. The minutes record how the new tool is to be used as "a quick glance communication sheet" intended to:

> Make all pertinent discharge planning information available to all disciplines in one spot and bring discharge planning to the forefront . . . it takes only 3-4 minutes to complete. . . it is a good up-front investment of time, as it saves time down the road when discharge is a priority (Minutes discharge planning worksheet, 1995).

Here the discussion of the discharge flow sheet shows how nurses' attention is focused on the organization's concerns. Taking only minutes to complete, the flow sheet shows "at a glance" the social coordination of the discharge. It produces, in nursing labour, an "up-front investment of time" in order to "save time down the road". It emphasizes the priority of discharge, which is an important feature of controlling bed utilization.

Participant observations revealed that front-line-nurse-leaders' work is dominated by cost-oriented activities. It is not that front-line-nurse-leaders' work revolves exclusively around finding beds and organizing nursing labour. However, they are the dominant concerns of front-line-nursing-leaders. Any other work accomplished seems to be "squeezed into" the many tasks that accomplish the work of finding beds and ensuring there is an adequate, closely monitored supply of nursing labour. They must manage resources efficiently and they must coordinate nursing efforts to accomplish this goal.

Front-line-nurse-leaders manage resistance

Restructured front-line-nurse-leader work requires them to be responsible for resource utilization of staff nurses and other allied health workers, including doctors, whose work

consumes the scarce resources the front-line-nurse-leader is responsible for. Not all nurses (and doctors) adopt cost-orientation as the standard for their practice. Some may hold notions about what makes for "a good investment of time" that differ from the managerial standpoint being promulgated through the flow-sheets and care-maps. Within the new leadership role, the resistance and intransigence of nurses (and doctors) who remain entrenched in the pre-restructured ideas and training is something to be "managed".

The implementation of the discharge planning flow sheet (Appendix I) provides an example of how issues of resistance are framed and dealt with. The minutes of the discharge planning flow sheet meeting document some of the opposition the team leaders encountered as they worked to introduce yet another documentary flow sheet into the pressured work of nurses in direct care. The minutes read:

> Some nursing staff do not feel it (completing the discharge planning worksheet) is relevant to their work with patients. (Minutes discharge planning worksheet, 1995).

Nurses who remain entrenched in their clinical practice interests must be coached to accept the importance of making room in their busy day to write up various management-focused texts. Despite the "quick glance" design of the discharge planning flow sheet, more management control is required to ensure nurses consistently use the form. It is this managerial work the front-line-nurse-leader was referring to when he commented "That is one of the things I am really trying to work on with the nurses". The minutes of the meeting offer more detail about the nature of this coaching work:

> We need education to help nurses see the significance of the social history in provision of holistic care (Minutes discharge planning worksheet, 1995).

In this case, part of the coaching work includes invoking a professional nursing discourse about 'holism' and 'holistic care'. Framing the discharge planning flow sheet within this nursing discourse obscures its interests in costs and resources (as did a "gerontological" framing" of ALC). Terms such as "holistic" call up a nursing framework that appeals to nurses' (and team leaders') traditional interests in patient care.[40] Activating the nursing discourse is one way that team leaders "work on" (manage) nurses' reluctance to adopt the efficiencies hospital restructuring calls for.

Other ways front-line-nurse-leaders coach nurses about their new responsibility to work within the efficiency framework is captured in this team leader's comment:

> The nurses know what is going on. I'll ask them "what is going on for this patient?" and they'll say, "well this is his first day". Now that is where you get into the senior/junior nurse. The junior nurse, the novice isn't as able to do that, so with the novice you have to prompt them, you know "This is what this person should be doing today, this is what is important.....we need to know are they on target"? That is why we came up with the standard care plan idea, our adapted clinical pathways. So the novice nurse can look at this and can say "they're meeting this....or they're not". It is written down so they can refer to it, and they can start to generate the discharge right away and there is no wasted time, it helps to keep them on target.

Although the team leader continues to rely on nurses' experience and knowledge "I'll ask them 'what is going on for this patient?' it is her/his duty to guide the nurses to ensure that, consistently, nurses' knowledge and expertise is being directed towards the desired efficiencies. A nurses' report – "well this is his first day"—becomes an opportunity for the team leader to coach, and to prompt. The team leader has textual tools to support the prompting work, the "standard care plan idea, our adapted clinical pathways". The team leader works with these to superimpose the managerial agenda into the work of nurses in

direct practice. Constant pressure – the physical line-up of patients waiting, mandatory documentation related to patients' progress toward discharge, and the coaching, monitoring and "managing" activities of front-line-nurse-leaders combine to insert cost-oriented rationing practices directly into the work of staff nurses.

Managing physician's resistance

Throughout the hospital reform of the 1980's and 1990's doctors have stood in strong opposition to managerial incursions to their professional autonomy and have consistently resisted attempts to monitor and control their billing practices (Armstrong et al., 1994, p. 23). In contemporary hospitals, clever strategies have been implemented as attempts are made to circumvent physicians' collective resistance and control individual physicians' cost-generating practices. Monitoring and managing a doctor's use of resources has been built into the restructured work of front-line-nurse-leaders. A patient services manager explained how this works:

> Recently I've had to work with a couple of team leaders who are really frustrated about their role. It's about the treatment that they receive from physicians because physicians can be awkward. They want their patient to stay. These patients being sent home probably means more work for the physicians. But if one of the team leaders says "This patient really is ready to go home they are just waiting for that ERCP (endoscopic retrograde cholangio-pancreatography). I suggest you send the patient home today and book the ERCP as an outpatient". Unfortunately some of the physicians can be difficult and it breaks down their working relationships a little bit.

Physicians hold a "privileged" relationship with the hospital; they are not employed by the hospital and are not as susceptible to managerial authority. This becomes a managerial problem to be solved. For front-line-nurse-leaders, managing physician's practices becomes complicated, stressful, political work that absorbs their time. A front-

line-nurse-leader talked about the thorny politics involved when she attempts to ration doctors' use of resources by organizing a patient's discharge.

> Now that they have taken away the role (of bed utilization reviewers) it is us that have to be the hammers to say to the docs "why is this patient here?". And you know, I always did that, and sometimes there would be certain physicians who were really bad about it. I could almost see them shudder when I approached because they knew I was going to ask the question. I didn't like that, because I don't want to be....like, the nag. I want to say: "How can we work together? What piece of information do you have that I don't? You know this person in the community. What can you tell me about why this person still needs to be here?" That is how I tried to put it. But I'm not always that successful and I'm sure I come across as being the big heavy hammer too sometimes.

Within the gendered politics of their work (Campbell, 2000), nurses are working to reconcile how their bed utilization responsibilities may be construed as "nagging" as they step across lines of authority with doctors.

Front-line-nurse-leaders are under a great deal of pressure to rein in physician's authority to discharge in order to appear to be competently doing their job. An interaction with a team leader during a participant observation highlighted the pressures, responsibilities and frustrations she experiences:

> On Thursday last week, it was so bad, we had two urgent meetings with all the team leaders, admitting and bed utilization clerks. There were patients tucked into all the corners and closets of the hospital. Everybody was over census. I had been desperately looking for beds all day. I was frustrated because on my ward there was a vaginal hysterectomy who should have been sent home. We weren't doing anything for her except feeding her Tylenol #3's but her doctor had been in at 8 a.m. that morning and she (the patient) had convinced him that she wasn't yet ready to go.

Front-line-nurse-leaders attend urgent meetings related to the dire shortage of beds. They are also caught up in the physical demands of having "patients tucked into all corners of

the hospital". They are pulled into, and are responsible for, the added burden this creates for their staff. Nonetheless, the authority for discharging patients rests with physicians and in this instance the front-line-nurse-leader is unable to negotiate the required discharge. As a result, she describes how her competence is called into question:

> Later in the afternoon, when we had the second meeting, I was really on the line. He had not been answering his pager and the ward was really going crazy. When they called us all back down I had to report that I had not been able to empty that bed. I knew they were not impressed, but I have to tell myself, I did everything I could.

Managing physicians' discharge practices is a now a requirement of front-line-nurse-leaders' work. When a front-line-nurse-leader is unable to demonstrate efficient discharge practices, her competency is questioned.

Front-line-nurse-leaders' competence is judged in relation to efficiencies

I have been showing how the new accountability to efficiency that is written into front-line-nurse-leader's restructured work transcribes managerial responsibilities for enforcement (of efficiencies) into their work. Also, how front-line-nurse-leaders' new managerial work disrupts their traditional role of clinical support. In the following section I detail how front-line-nurse-leaders new responsibility to manage for cost efficiencies is itself enforced, and how the nurses who take on these roles are held accountable, and judged competent, based on their ability to develop a cost-oriented focus through which they efficiently manage bed and labour resources.

Health information technologies have a built in capacity to objectify and constitute "inefficiencies" through recording, and through measurement and comparison. Health information makes public such accounts of inefficiency that have this objectified basis.

These technologies generate data that can be broken down and compared, one unit to the next, using methods that "show up" an individual nurse-leader's "competence" with the new (ruling) demands of her job. It is information/knowledge/data such as these to which front-line-nurse-leaders are held individually accountable.

In several hospitals I studied, strategies are in place that generate a business-like model of interdepartmental competitiveness to enforce efficiencies.[41] One of my nurse informants who works in a hospital that uses the contracted services of the American based MCAP™ bed utilization company remarked ruefully:

> Each day we have a "bed meeting". All the clinicians gather in a little room and we report which beds we have managed to clear. Then the waiting patients are doled out amongst much haggling about workload and off index (e-mail communication, April 2000).

In the MCAP™ system "off index" days equate to "lag days" or "ALC" days. Statistically, they represent an inefficient utilization of resources that the front-line-nurse-leaders , (at this hospital called "clinicians") are held responsible for. My informant is describing how front-line-nurse-leaders are reluctant to admit patients to their units whose age, social circumstances, and needs for care are constituted, within accountability systems, as inefficiencies. On a number of occasions I have heard these sorts of patients referred to as "bed blockers". My informant describes the "haggling" front-line-nurse-leaders engage in to avoid taking on these patients. My informant continued:

> Each month all of the clinicians and the physicians wait with bated breath to see how many "off index" days we had. The implication being of course that the doctor is a "BAD" doctor if he has too many off index patient days and that the clinician on the ward

> is not doing the job of "moving her patients out" appropriately if we had too many "off index" days (e-mail communication, April 2000).

Nurses in front-line-nurse-leadership positions are held accountable to the new "facts" generated through the technologies of counting. Through technologies of counting, such as the MCAP™ system described here, front-line-nurse-leader's day-to-day practices of managing patients can be publicly scrutinized and compared. Front-line-nurse-leaders may be judged incompetent if they are unable to "measure up" to the standards generated by this competitive milieu.

Patient satisfaction technologies, such as the one my aunt Hannah and I responded to, also produce public scrutiny used to generate competitive relations against which "competency" may be judged. At the hospital where Hannah was treated, I secured an interview with the "coordinator for hospital evaluation" who was responsible for conducting the survey. The interview helped me to identify how information technologies such as patient satisfaction are used to re-orient the professional work of front-line-nurse-leaders and nurses-in-direct-practice. The coordinator explained how patient satisfaction surveys are conducted and how the data is handled. An extensive patient survey is conducted every three years. The patient satisfaction survey Hannah and I responded to was conducted in 1998. Patients are randomly selected from a 3-month period of hospital admissions. In 1998 three thousand surveys were distributed (n = 1000). Data is grouped and reported under clinical practice units and are distributed to the managers of each CPU "for action".

Front-line-nurse-leaders are expected to respond to "issues" (the virtual reality) generated through aggregating patient satisfaction survey data. The coordinator of hospital evaluation expressed concern that, the survey data was "underutilized" and discussed strategies being developed to generate increased compliance. She said:

> In the 1998 survey the findings were not well used by three of the hospital business units; surgery, medicine and family practice did not respond to the data.

Citing the expense and complexity of running the satisfaction surveys the coordinator for hospital evaluation went on to say:

> We are addressing that though. In preparation for the next survey we have asked all the unit managers to sit on three committees that will involve them right from the planning stage. We are going to get their input in how to organize the data to make it useful for them. If we can get good buy-in from the start of the project they will be more invested to act on the data when we get it.

Getting front-line-nurse-leaders to "buy into" the satisfaction process echoes the "buy-in" sought by the unit manager of orthopedics during the implementation of clinical pathways. "Buy-in" is one of the ubiquitous concepts associated with successful implementation of managerial strategies. It reflects what I have introduced as the development of organizational consciousness. All these strategies (counting, comparing, standardizing, teaching, coaching, announcing and so forth), inserted into the practices of nurses in direct practice *and* (somewhat differently) into the practices of nurses in front-line-leadership, enforce adherence to managerial approaches for operating a hospital as though it were simply a business.

Patient satisfaction technology contributes one more piece to the complex of ruling relations that divert front-line-nurse-leaders attention away from the everyday/everynight

clinical goings on of nurses and their patients. As I displayed in Chapter Four, patient satisfaction technologies insert a particular "way of knowing" about health care that refutes other, differently situated, claims. In this case patient satisfaction is aligned with Patient Centred Care, which, as described earlier, is an efficiency-oriented, restructured approach to delivering hospital services. The technological/managerial alignment of patient satisfaction with Patient Centred Care re-constitutes everyday knowledge about what is actually happening in health care. It produces a textual/objectified evaluation and accounting of what is going on (the hyper reality). For front-line-nurse-leaders patient satisfaction technologies place a new emphasis on customer relations that, compared across "teams", produce competitive relations. Patient satisfaction is an administrative technology that is being used to support increasingly sophisticated corporate strategies of reform. Technologies such as patient satisfaction and MCAP^{TM} contribute to the broad set of enforcement strategies implicated in the reformed (now taken for granted) managerial work of front-line-nurse-leaders *and* nurses-in-direct-practice.

In pragmatic terms, in the hospital where Hannah was a patient, the front-line-nurse-leader, now called a Clinical Practice Unit Manager (who may or may not be a nurse) is responsible for a multidisciplinary group of workers (speech therapists, occupational therapists, housekeepers and nurses etc.). In the Patient Centred Care literature, the work of the clinical practice unit manager is "critical to performance" (Gerteis et al. 1993, p. 233). And, as my interview with the coordinator of hospital evaluation attests, these managers are also integral to the "feedback loop" of patient satisfaction data. Managers are offered instructions that enforce attention to the virtual reality of "problem rates"

within defined categories considered critical to the success of the re-engineered work processes. More and more, front-line-nurse-leader attention is focused on textual problems, as professional knowledge of people's lives and experiences are displaced by the virtual reality.

What actually happened between Hannah and Janet and the Clinical Practice Unit Manager

When a front-line-nurse-leaders' attention is captured within a virtual world of data driven relationships, then that leader's attention is diverted away from actual nurses, patients and families. It was my experience that problems arose for nurses and their patients by the deletion of a regular (practice based rather than managerial) nurse in charge who is able to track and attend to the day-to-day concerns of patients and nurses. In the case of my aunt's injury, I have suggested several serious consequences of not having the nursing leader focus her attention on nursing care.

The coordination of the always contingent and unpredictable direct care work of the nurses has been altered within the re-engineered approach to Patient Centred Care. What this meant for Hannah was that there was no continuity of a nurse in charge who was overseeing the direct patient care issues that emerged during her ten day stay (as there would have been in the past with the old "head nurse" model). Rather, (according to an interview I conducted subsequently) any nurse coming on duty for a shift might be assigned to be in charge. This nurse is responsible for such things as assigning nurses to look after patients and for monitoring the general acuity and nursing response to all the patients on the unit. This is the vision of Patient Centred Care's self-directed teams. In

reality, the charge nurse is frequently unable to carry out these coordinating duties. In part, this is because she rotates through the charge position and does not have opportunity to "really know what is going on" (staff nurse interview) with patients and staff. Also, in addition to the responsibilities of being in charge, the charge nurse has her own group of patients to care for, and constantly juggles the needs of the general ward nurses (and their patients) against her own needs and the needs of the patients for whom she is personally responsible.

Problems developed for Hannah when there was no nurse who "knew" her well enough to direct individualized, contextualized assessments and interventions. A constantly changing stream of casual (on-call) nurses compounded the problems. Hannah became constipated as a result of the painkillers she was taking. This was overlooked for several days. Her intravenous access was not changed for seven days at which time it became reddened and painful. When Hannah experienced chest pain, there was no one available to respond to events in an individual way, no one who had been following Hannah's progress with whom the nurses-in-direct-practice could consult. On almost every occasion Hannah received a hurried or standardized response to her symptoms that from the perspective of my own professional knowledge, displayed marked inadequacies.

Nor was the CPU manager able to help. The severe (800 cc) fluid restriction ordered for Hannah was not reviewed for several days. Worried about Hannah's significant thirst I approached the nursing desk and asked to review the daily sodium results. I was referred to the clinical practice unit manager who was called from her office, located some

distance from the unit, to speak to me. The manager tried to be helpful, but she explained how family access to this sort of information is restricted to the availability of someone to explain and interpret it. My interest in my family member's thirst became an "administrative" concern about family access to documents. Thus, on this occasion, despite the fact that the manager was a nurse, she did not orient to the clinical concerns of a patient on her unit. She was unable to respond satisfactorily to my concerns regarding my relative's pleas for more water.

Patient satisfaction technologies offer instructions to nurse managers to "handle patient complaints in a way that leaves the patient satisfied and also reduces the risks of patient litigation" (Messner and Lewis, 1996, p. 37).[42] Survey technologies used by restructured hospitals are part of the new business-like approach to hospital management. Front-line-nurse-leader's attention is systematically diverted to text-based administrative technologies (such as patient satisfaction, bed utilization and, in this case, legal aspects of sharing patient information) that have produced new accountability structures for nurses. The restructured work of front-line-leadership requires nurse managers to use text-based administrative knowledge to make decisions related to patients. This constitutes a new accountability structure, *for nurses*, constructed and enforced through computerized management of patient data. Nurses' professional competence becomes judged through competitive relations associated with issues such as patient satisfaction, bed utilization, readmission rates, average length of stay and so forth. Front-line-nurse-leader's attention is captured within this virtual world of data driven relationships diverting attention away from actual nurses patients and families. Not only have nurses lost a clinical support

system necessary to their ability to perform their work, but also, that system has been harnessed to the service of producing cost-oriented outputs.

Chapter six conclusion

Front-line-nurse-leaders straddle a "line of fault" (Smith, 1987) between the "virtual" reality of the management technologies, and everyday, local knowledge about how nursing units are organized and nurses' knowledge about patients. Front-line-nurse-leaders act as a conduit, an "interchange" point (Pence, 2001) for the imposition of objective, textually mediated conceptual practices into the local setting. The restructured front-line-nurse-leader work is distinctly "administrative". Constructed within official job descriptions the work includes responsibilities for "utilization", "quality assurance" and the implementation of "effective nursing care routines". The work of the new front-line-nurse-leaders has been developed to make nurses' actions, and the activities of the nursing unit accountable to administration.

The re-oriented work of front-line-nurse-leaders involves them in many meetings where their competent demonstration of efficiency practices is enforced. Some of these meetings produce a "public" venue in which their responses to the demands of the organization are scrutinized (bed meetings, MCAP^{TM} meetings, meetings about patient satisfaction data and so forth). Other meeting time is devoted to develop tools and to strategize approaches for enforcing efficiency work into the practices of nurses in direct practice (orthopaedic pathways, discharge planning worksheets, ALC orientation,

"whistlestop" inservices and the like). Yet other meetings are with senior nursing management who coach and support the front-line-nurse-leaders. This coaching and supporting work includes activities such as "working with a couple of team leaders who are really frustrated about their role" and "developing the team leader role" in order that team leaders "get better at bed utilization" (Interviews, patient care managers). Overall, the front-line-nurse-leaders attention is systematically diverted away from the "traditional" duties of mentoring and supporting nurses in direct practice and of expertly intervening in the complex clinical situations that arise.

My fieldwork data suggests that the intersection of nurses' new business-like managerial work with physicians produces a formidable contested terrain. Nurses identify physician's authority over discharges as one of the barriers to their ability to produce an efficient nursing practice. Managerial technologies that can systematically determine whether or not patients meet specific "criteria" to warrant hospitalization are authoritative tools that front-line-nurse-leaders use to address the doctor/nurse power imbalance. Nurses support the use of these sorts of technologies, discovering that the authorizing features of numerically based "objective" data gives them some sway within their thorny professional relationships with physicians.

A question remains, though, about how front-line-nurse-leaders, generally experienced nurses committed to patients and their care, are so effectively organized to assimilate the new knowledge practices of efficiency. Why are they not more resistant to the features of their work that take them away from patients and nurses? Similarly, how has it happened

that nurses in direct practice, although clearly troubled and unhappy, are able to rationalize the new efficiencies and, like Nurse Rushing in the previous chapter, to turn their attention to "efficient use of resources" and "all those patients waiting"? In the final chapter of this dissertation I take up the issue of nurses' "professional knowing" to examine how the organizational consciousness I have been describing can be "understood" as conforming to professional conceptions of nursing as a "dynamic, caring, helping relationship in which the nurse assists the client to activate and maintain optimal health" (CNA, 1987).

Chapter Seven

Colonization of nurses' language: An evolving professional discourse of efficiency

Introduction

In this chapter I turn my attention to nurses' *language use*. I argue that a particular use of language helps to accomplish a "fit" between nurses' cost-oriented efficiency practices and the professional values, codes and standards that nurses are expected to uphold. This fit however, is illusory. The traditional values and standards encoded in nursing are actually being reshaped. Nurses' language is evolving in step with reform and restructuring. Language plays an important (generally unchallenged) part in how nursing is changing. As I show in this chapter, the language of business, as employed in hospital management, enters nurses' discourse and is reordering nurses' understanding of proficient nursing.

Smith (1999) calls attention to how "speech and writing can be explored for how they coordinate or align individual consciousness, hence as *organization*" (Smith 1999, p. 142, original italics). Relying on Smith's theorizing about speech and writing, I listened analytically to nurses' talk and read nurses' professional discourse critically to try to understand how nurses' language works. In particular I paid attention to how management technologies take up "nursing words" to implement efficiencies, and how nurses take up "management words" as though they belong to nursing. A "double relation" (Smith 1990b) develops through which nurses are organized to understand nursing in a different way. Nurses are organized to read and use nursing discourse and to

find in it a rationale for substituting attention to health care costs for other traditional nursing interests.

I focus my analysis on nurses' use of language within spoken and textual "speech genres" (Bahktin, 1986; Smith, 1999) to explicate how language circulates interpretations that nurses and managers may "know in common" and how new business-like interpretations are being accepted as the conventional facts of nursings' professional "body of knowledge". I unravel how nursing language is appropriated to accomplish a cost-oriented professional nursing practice. Smith (1999), and others (Mead, 1992; Bakhtin, 1981, 1986; and Vološinov, 1973) insist that language is generated within social acts. I explore the social acts of nurses' participation in "utterances" – writing/reading/speaking/hearing/acting – to closely track the social and textually-mediated practices of nurses' knowing. I show the language of efficiency dominating, both as spoken in hospital workplaces and in discussions in the nursing literature. Nurses learn to speak the language of efficiency and begin to enact its practices.

The conceptual language of nursing – the intellectual bridge for restructuring nursing

Nurses' activation of their professional practice requires them to be fluent in the use of an abstract, conceptual language. Campbell (1995) writes about how student nurses are taught to organize their nursing activities within conceptual frameworks making the point that this conceptual framing of nursing distinguishes contemporary nursing from what went before. The history of nursing is of a "hands-on" practice, taught through "training" in apprentice-like educational programs. Campbell claims that nurses learning how to

orient their nursing practice to abstract theories of nursing marks the "academicization of nursing" (e-mail communication, May 2003) that has evolved over the past several decades. She argues that:

> In nursing, theory-based practice is part of an increasing professionalization of the work which depends on building an intellectual bridge between nursing work and scientific knowledge. Presenting nursing as an academic discipline which requires students to learn to think and do nursing in relation to abstract theories of nursing is a professional achievement of the past several decades (1995, p. 222).

The nursing curricula provides the site where nurses learn to organize their nursing work around scientific concepts and research. Nurses also learn to understand nursing in relation to abstract concepts in the workplace and through their writing and reading articles in their professional journals and by discussing their nursing practices with other professionals. Nurses come to recognize themselves and their everyday nursing situations within the abstract theories that have been developed to sort out, scientifically, peoples' need for nursing care. Nurses are expected to be able to explain nursing activities as professional, research-based practices.

At the conjuncture of nurses using theory to undertake nursing and nurses confronting hospital restructuring, a specialized language emerges. Recall the minutes of the discharge planning flow sheet meeting (discussed in Chapter Six, p. 170) where the front-line-nurse-leaders identified:

> We need education to help nurses see the significance of the social history in provision of holistic care (Minutes discharge planning worksheet, 1995).

"Holistic care" is an example of one of nurses' theory-based, abstract concepts. Holism, written about in nursing texts, references "the physical, emotional, social, economic and

spiritual needs of the person" (Potter and Perry, 1997, p. 1485). As a concept, holism does not describe actual activities (such as the "holistic" activities of a nurse I observed who was assisting an elderly hospitalized patient make satisfactory arrangements for the care of her aging dog). Even Potter and Perry's definition is itself based on conceptual abstractions that do not make visible the materiality of people's needs or the sorts of *activities* that "holistic care" apparently references. Nonetheless, nurses skilled in navigating the intellectual bridge between nursing work and scientific knowledge are able to do the mental work required to recognize nursing practices that "fit" the conceptual frame of "holistic care". The reference to holism being made in the discharge planning flow sheet meeting relies on nurses' ability to think and do nursing in relation to abstract theories of nursing practice. However, in this instance, nurses' abstract theoretical language is being used to reference managerial practices of efficiency.

In the discharge-flow meeting, front-line-nurse-leaders are planning to teach nurses to translate expeditious discharges into a representation of an holistic practice. I learned from my field research how to make sense of the juxtapositioning of "social history" and holistic care. Nurses are taught to recognize that people are more comfortable in their own homes than they are in the busy institutional setting of the hospital. Learning about the patient's home context, identifying available supports, and identifying barriers to the patient's ability to manage at home seems to "fit" with the nursing concept of holism. In actuality, though, the *activities* this apparently "holistic" practice organizes is the work of completing a bureaucratic form that initiates "automatic referrals" for patients who, in texts, meet certain pre-established criteria. This form-filling work expedites discharges,

attends to "bed pressures" and increases the hospital's productivity. This is the ruling relation for which the nursing term "holism" is being harnessed.

Language, double relations, speech genres and discourse

For the purposes of my analysis I use Smith's (1999) notion of the double relation of words and language, and her discussion about discourse[43] and speech genres to unravel how language "works" in the restructured practices of nurses. Smith (1990b, 1999) had seen in her own research, conducted in a newsroom of a city newspaper, how she and her co-researcher Nancy Jackson observed and collected reporters' conversational use of the words "assign" and "assignment". Smith describes how, falling into error, she and Jackson "began constituting assignments as if our object was to describe them" (1990b, p. 95). She writes:

> Our observational procedures were useful, though our objectives were problematic. We kept a record of the ways in which reporters talked about assignments, or used the associated verb 'assign' etc. We found we had a collection of overheards which were not readily intelligible . . . these were normal uses of the terms 'assignment' and 'assign' which could not readily be made sense of without a knowledge of the actual working practices of the newsroom.

Nonetheless, Smith describes how, with this "collection of phrases" she and Jackson

> . . . began to construct "something" that we could describe as an assignment . . . We found a definition that would reference all these instances (p. 96).

Inadvertently they had created a "sociological category" through which to reference all the occasions in which the use of the word "assignment" arose. Smith and Jackson came to recognize how their research approach created a problem. Their work with the reporters' utterances of "assignment" resulted in "two contexts of use and two methods of

reading it – those of the sociological discourses and of the original setting" (p. 97). Smith recognized how the same set of terms located in two intersecting social relations creates a "double relation". She explains:

> When we bring this double relation into view, we can see more clearly the problems that arise in descriptions when the descriptive language is organized by the sense-making practices of the (sociological) discourse. In that context they (the descriptive terms) "work" quite differently from how they operate in the original setting they now describe... In the back of the two disjoined language-games is a particular form of the class relation, where the formalized professional discourse of bureaucratic process on the one hand confronts the lived world it seeks to name, manage, control, and organize within its conceptual and practical jurisdiction (Smith, 1990b, p. 100).

Smith's analysis pulls into view (for me) how words and phrases used to represent something on the ground of nurses' work can mean (and produce) something entirely different when used by others not directly involved in nursing's embodied practices with patients. At work, staff nurses' talk is dominated by the need to communicate their actual labour with patients. Nurses can be overheard talking about "who still needs morning care?"; about "taking out So-and-So's PCA"; about "phoning his wife to bring in a razor"; about how "she needs more teaching before she can go home with that SP catheter"; about "calling the surgeon about So-and-So's calf pain or serum electrolytes"; or about "calling staffing office for workload for the overflow".[44] Actively producing embodied nursing practices; nurses' talk at work is vernacular and colloquial in tone. While it brings words from other disciplines into it (i.e. "workload" and "serum electrolytes"), it arises in and expresses the embodied work and activities of the actual people in the setting. In contrast, the formal conceptual language of professional nursing, the words that are used to *describe* nursing – such as a managerial use of the term "holistic" to reference a form-filling exercise – "perform a lexical suppression of the

presence of subjects and the local practices" (Smith, 2001, p. 160). In this suppression, the "class relation" Smith (1990b, p. 100) noted is apparent, the ruling of the everyday by new forms of text-based regulation.

Nurses' use of the term "quality care" is a good example of the double relation, lexical suppression and class relation that Smith points to. I interviewed a nurse from NUC who was involved in the care of a woman who had undergone gynecological surgery. The patient had inadvertently been sent home before her vaginal packing had been removed. The nurse I interviewed told me about how this serious oversight had been discovered, some days later, by a home care nurse who had been visiting the patient to address the patient's ongoing difficulties urinating. Grounded in detailed recollections about the patient's urinary and catheter problems in the hospital, and the interactions she had with both the patient and another nurse who cared for the patient while she had been hospitalized, my nurse informant criticized the "quality of nursing care" the patient received. In contrast, when I was interviewing a Patient Care Director, she referred to the "quality of nursing care" in a very different context. In the story she told, she discussed "quality" in relation to the average length of intensive-care stay for patients who had suffered myocardial infarction (heart attack). She was not referencing a specific incident, but basing her knowledge about quality on the unit's performance statistics over a six-month period (within the context of changes in the "staffing mix"). "Quality of nursing care" as this Patient Care Director discussed it, represented (and accomplished) something quite different than the "quality of nursing care" referenced by my informant in direct care. In the back of these two disjoined expressions of "quality", the *managerial*

use of the term is a powerful regulator for "understanding" any problems that may exist in the lives of nurses-in-direct-practice. The managerial use of quality has an authorizing capacity that can be used to "name, manage, control, and organize" (Smith 1990b, p. 100). It is a much more influential account than the accounts of "quality" provided by nurses in direct practice. For example, it was this sort of managerial description that informed and authorized how the nursing consultants' at the NUC hospital could be "impressed with the high quality of care provided" (External Nursing Review, June 19th, 1996), despite hearing the troubling stories collected by the nurses of NUC.

My example of the two accounts of "quality care" reveal how despite the fact that both informants used the same term, they were talking about distinct (and distinctly different) phenomena. Following Bakhtin (1986) I see this double relation of the term "quality" as arising in and being part of two different speech genres. Bakhtin notes that while:

> language is realized in this form of individual concrete utterances (oral and written) by participants in various areas of human activity . . each sphere in which language is used develops its own relatively stable types of these utterances. These we may call *speech genres* (Bakhtin, 1986, p. 60)

In the two interviews with nurses who each referenced "quality of care", the *sense making practices* each speaker used in her account of "quality" (and that I, as competent listener, was also able to call up) arose from two distinctly different speech genres. According to Smith (1999) a speech genre is:

> Developed in the context and bear(s) the imprint of the characteristic usages associated with the activities of a group – a work organization, a professional practice, the experience of a generation, and the like (p. 120).

Each informant's account of quality bore the imprint of the characteristic uses associated with the term "quality" within its own speech genre. One use (and interpretation) of "quality of care" arose from a nurses' knowledge and experience about the specific clinical care required by a patient following a specific surgery. The other was based in a numerically-based hyper reality, a management strategy developed to save money. Each made sense when properly contextualized, but in the manager's account a class relation was apparent as both her account and the decisions and activities her account produced express a relation of ruling within the hospital setting.

Despite how I contrast the two "interpretive schemas" my informants called up when they discussed "quality of care", the context of direct-practice-nurses' use of the term "quality" is shifting. Nurses' utterance of "quality" is evolving in alignment with the ruling schema of management technologies of restructuring. During my work with the nurses of NUC they frequently commented that their concerns were "quality of care issues". They used this term to *both* reference a traditional interpretive schema of "quality" (as understood by the nurse who was describing a serious oversight in the care of specific patient) *and at the same time* applying the interpretive schema of "quality" embedded in the "quality" technologies (as used by the nurse manager when she discussed the quality of care for cardiac patients). Despite the frustrations encountered by the NUC nurses when they initiated Quality Assurance (QA) forms, the nurses *expected* the technology to work in the interests of patients (and nurses). They expected that what was being accomplished through their involvement in the QA process was *their* interpretation of quality. The double relation hooks nurses into the managerial

technology but the "fit" between their understanding of the meanings of quality of care and the ruling practice is illusory.

The ideological code of efficiency across speech genres

The socially mediated practices of nurses' knowing/speaking/reading/writing about nursing (such as nurses' use of the term "quality care") are not limited to their professional discourse, their nursing education or their work experiences. Nurses' competence in knowing how to conceptualize nursing practice correctly is also informed by ideas and knowledge circulating in society. In Chapter Three, following Smith (1999) I proposed the notion of an "ideological code of efficiency". The code of efficiency (with its underlying interest in market competiveness) is prevalent across contemporary political economic discourse (C.D. Howe Institute, 2000; Fraser Institute, 2000, Hudson Institute 2000, Canadian Business) and enters into divergent sites, including popular media. The code represents an ideology organizing policy and political practice. Workman (1996) argues that "the discourse of fiscal crisis . . . draws upon notions and ideas embedded in everyday life. Rather than challenging day-to-day intuitions, it is assisted by them" (p. 13). His point is that (in 1996) a Canadian 'fiscal crisis" was understood and widely accepted as existing. Workman notes how Paul Martin, then federal finance minister, stated in his 1995 budget address: "The last thing Canadians need is another lecture on the danger of the deficit" (Cited in Workman, 1996, p. 12). Martin could safely assume that widely held beliefs about a "debt crisis" make "restraint" measures infinitely reasonable to most Canadians.

The ideological code of efficiency hooks a variety of audiences into practices of reducing the debt and deficit through measures of efficiency. Nurses, as Canadian citizens and consumers of mass media are hooked into the "common-sense" making practices about the dangers of "living beyond our means". The ideological code of efficiency is spread across speech genres.

My reading of nursing literature suggests that the ideological code of efficiency infects nurses' ideas as it circulates not only throughout the popular press but also within nurses' professional publications. There, efficiency has become a central theme of nursing itself. In nurses' text-mediated discourse, the sense-making practices that are generated through the ideological code of efficiency paves the way for the evolution of a new genre of speaking/writing/reading/practicing nursing. In this evolving speech genre, nurses' words are appropriated for management use and management words are inserted into the nursing lexicon. In this blurring of language, the interests of nurses, previously stabilized by the utterances of nurses' traditional genre, are destabilized and displaced. The evolving "nursing" speech genre bears the characteristic imprints of a generation of nurses whose ideas about nursing have been influenced by the ideological code of efficiency. The code carries a political force – is a ruling relation – representing what is or what should be happening in nursing.

"Efficiency" in nursing evolves

Language evolves as the social practices being expressed change. How nurses understand and practice efficiency is a case in point. Nurses have always been taught the importance of being efficient. For nurses, efficiency is a consideration of all nursing

work in relation to coordinating therapeutic intervention and overall use of time and energy. In my own 1970's diploma nursing education I recall being told that my first priority was patient safety. Avoiding risk to patients was always to be foremost in my attentions and plans. Once safety was attended to, I was instructed to attend to patient suffering and to provide comfort. Finally, I was told, I was to attend to "efficiency" – the most practical way of accomplishing the work. I had to be organized, sequencing my tasks to use my energy sensibly to make sure I completed the required work in a reasonable amount of time. "Safety, comfort and efficiency" became my organizing mantra (and likely the mantra of my nursing generation) for making nursing care decisions.

Over the intervening decades, the language of efficiency as I was introduced to it, has taken on a new "business-like/managerial" inflection. In 1984 when I attended the University of British Columbia to complete my nursing undergraduate degree, a requisite course on management was included in the core curriculum. In my assigned readings, efficiency was framed quite differently than I had learned about it previously. The required course text put it this way:

> Efficiency is a vital part of management. It refers to the relationship between inputs and outputs. If you get more output for any given input, you have increased efficiency. Similarly, if you can get the same output from less input you again increase efficiency. Since managers deal with input resources that are scarce - money, people, and equipment – they are concerned with the efficient use of these resources. Management therefore is concerned with minimizing resource costs. It is not enough to be merely efficient. Management is also concerned with getting activities completed; that is, it seeks effectiveness. When managers achieve their organizations goals, we say they are effective. So efficiency is concerned with means and effectiveness with ends (Robbins, 1984, p. 5).

In this excerpt, nurse readers are offered tools to develop an interpretive schema of efficiency that is different from how I already knew the word efficiency. Through this assigned text in a nursing undergraduate course, nurse readers are introduced to instructions for reading "efficiency" with its industrial/commercial inflection. This definition represents managerial interests. The management discourse has developed its own vocabulary around efficiency with systematic interests in inputs and outputs as part of managing the labour/production circuit. Within this frame, I was being taught to activate "efficiency" differently. Formerly my responsibility for efficiency related to my own skills. My individual clinical judgement, priority setting and time management were at the centre of that form of efficiency. Now I was being involved in an efficiency that encompassed broader organizational considerations, in which I was being prepared to participate, in various ways. Efficiency here represents activities of rationing resources, which I have argued, have become practices that rule nurses' work. It is within this managerial interpretive schema that "efficiency" continues to evolve as it is written into the new job descriptions of front-line-nurse-leaders (Chapter Six). This schema pulls in organizational interests of "scarce resources", "money" and "the bottom-line". It guides nurses to conceptualize their activities as "inputs" and patients as "outputs" and promotes a nursing interest in rationing – doing "more for less".

In a (1999) text on organizational behaviour, Robbins and Langton demonstrate the salience of efficiency for other sites of public service. In this text, Canadian public service and health care are broadly framed within "the country's major industries" and public service is entrenched in a business/market orientation. Citing trade and export

figures, Robbins and Langton conclude, "in terms of *services*, more interest and dividends are paid out of the country than into it" (p. 18). Thus framed, Robbins and Langton repeat the previous definition of efficiency adding:

> A hospital is *effective* when it successfully meets the needs of its clientele. It is *efficient* when it can do so at a low cost. If a hospital manages to achieve higher output from its present staff by reducing the average number of days a patient is confined to a bed or by increasing the number of staff-patient contacts per day, we can say the hospital has gained productive efficiency (p. 18).

In Robbin's updated 1999 edition, hospitals are explicitly and unproblematically included as a site for business efficiency. The authors suggest that "Canadian managers must become much more oriented towards productivity in order to make our goods and services competitive in the global market" (p. 12).

A new meaning of efficiency has been carried from its home in business (inputs and outputs) through the burgeoning field of nursing management (Hibberd and Smith, 1999) for use in the mouths (and, as I go on to demonstrate, the professional texts) of nurses-in-direct-practice. Nurse Rushing's explanation about "efficient use of resources" produced fundamentally different activities than my 1970's lessons in "safety, comfort and efficiency". Nurse Rushing, discharging a confused and incontinent post-operative patient into the care of his wife, possibly jeopardized the safety of both partners of this elderly couple. Nurse Linda also contravened the mandate for her patient's comfort when she discharged a decidedly nauseated patient without appropriate treatment. While these nurses may recognize that this sort of nursing care is not optimal, it may be that they felt they had no choice. Or, they may belong to the group of nurses who have accepted the

importance of minimizing the use of resources for cost-savings as a nursing priority, and for whom these approaches to patient care represent a skilled practice.

Efficiency has evolved both in nurses' language use and in nurses' practices. It has been infected by a business-oriented notion of efficiency. Efficiency now produces a double relation. On the one hand it is still used to teach individual nurses to be well organized. On the other hand it is related to making nursing care more cost-efficient. The business-oriented version of efficiency, which is taking over nursing, is coded into almost every aspect of public discourse (the fiscal crisis and the unsustainable level of public service spending). This reinforces the message and thus the evolution of cost-oriented efficiencies into the practices of nurses.

Nurses' cost-oriented efficiency practices and the ideological code

Efficiency, as an ideological code, works in so far as it carries all its ideas into peoples' understanding *without the necessity of analysis or evidence*. Ng, (1995) explains:

> Once an ideological frame is in place, it renders the very work processes that produced it invisible, and the idea it references as 'common sense'. That is, the idea(s) contained within the ideological frame become normalized; they become taken for granted as 'that's how it is' or that's how it should be'" (Ng, 1995, p. 36)

The common-sense making practices of the ideological code of efficiency are present in many of the interview excerpts and observations of nurses' practices that I have been using throughout this analysis. As Ng asserts, the work processes that produce nursing efficiencies have become almost invisible, taken-for-granted aspects of contemporary nursing. Nurses do not analyze or demand evidence for the *requirement* for strategies

that improve the "efficiencies" of the hospital production line. Efficiency is a ruling relation in their work.

It is not only in the highly pressured everyday settings of scarcity that the taken-for-granted business-oriented messages of efficiency get passed into nurses' language. In the professional texts nurses read to support and inform their practice, the ideological code of efficiency produces an underlying schema for nurses. An example of how the ideological code operates in nursing discourse is evident in a publication by Sandhu, Duquette and Kérouac (1992).[45] These nurse authors describe a "managed care" strategy in which "The care is geared towards reducing the number of hospital days for a patient" (p. 33). The taken-for-granted necessity of adapting nursing practices to respond to the Canadian fiscal crisis is evoked as they write "However, in these times of monetary constraints, nursing administrators are desperately looking for a means of reducing costs of care in institutions" (p. 33). The authors describe, in some detail, the advantages of the managed care assignment patterns describing how they "achieve clinical excellence and improve quality of care" (p. 34). In their conclusion they explicitly activate the ideological code (and the assumptions it calls up) by writing about "the expectations of societies in the 1990's" (p. 34). They conclude:

> The assignment patterns in which we provide nursing care have to be congruent with the expectations of societies in the 1990's. We strongly believe that the best advantages for patients and society rely upon better efficiency in caring. As the care we give determines the recovery time of the patient, as clinical nurses, we need nursing assignment patterns to help us meet this objective. Caring underlies the well-being of patients and empowerment of nurses. As nurses, are we ready to assume more autonomy and decision-making power as well as responsibility and accountability vis-à-vis patients, health professionals and employers? (p. 34).

The code is visibly active in this nursing text. It is normalized – "this is how it is". That nurses must adapt is also normalized. The ideological code of efficiency is active across many nursing texts. When the ideological code is in place, the "problem" is automatically named (without empirical analysis). The "code" stands in for the full explanation of the problem. Analysis is bypassed and the solutions are accepted on faith. In the article cited above, not only is the ideological code evident, but so too, is the evolving, double sided language. References to "efficiency in caring" "accountability" and "responsibility", as they are used here, evoke nurses' *own* (altruistic) professional ideas – they are used here, in a managerial publication, to reinforce nurses' conception that controlling costs "fits" as a legitimate nursing interest that nurses must learn to attend to. Nurses are expected, both as caring nurses and as caring citizens, to respond to the need for cost-reductions in order to achieve the " best advantages for patients and society".

Nurses' language is being appropriated for restructuring

I am suggesting that a *cumulative* adoption by nurses, of language organized within a double relation (within the ruling relation of the ideological code of efficiency) is a powerful strategy for restructuring hospitals (and nursing). I demonstrate two ways that this happens in language: 1) Nurses' own speech genre is being employed (co-opted) to reference the new business-oriented policies and programs and 2) Nurses take up terms that have their home in management practices and use them as though they belonged to nursing. Patient Centred Care and ALC provide examples of how nursing practices are being driven by the managerial speech genre of hospital restructuring.

Patient Centred Care

"Patient Centred Care" (the strategy that re-engineers the work organization in hospitals to accomplish cost-effectiveness) expresses a managerially useful "double relation". In traditional nursing language, patient centred care[46] refers to an essential feature of a competent nursing practice. Patient centred care is discussed as a way "to truly connect with patients as partners in care" (Weston, 2001, p. 438). In hospital restructuring many claims are made about the potential benefits of Patient Centred Care. At its heart though, it is strategy to control costs (Armstrong and Armstrong, 1996). Nonetheless the use of the term – "Patient Centred Care" – (as opposed to the term "product-line management", the industrial model it replicates (Gustafson, 2000, p. 31) accommodates nursing interests. My argument is that this manipulation of language constitutes a restructuring strategy.

Through the managerial use of a term that accommodates the (traditional professional) interests of nurses, nurses are being pulled into a different speech genre that aligns them to hospital restructuring. Within this evolving genre, "nursing" interests in patients and patient care become indistinguishable from managerial interests (those of organizational efficiencies and cost-containment). This is apparent in a publication distributed by the Registered Nurses Association of British Columbia, the professional organization regulating nursing practice in BC. Here Patient Centred Care is described as work design intended to deliver "greater accountability for the effectiveness and quality of patient care, improved strategic planning (and) improved cost control" (RNABC, 1996b, p. 3). In this quote, set afloat in a professional publication, the words "accountability",

"effectiveness" and "quality of patient care" carry with them the same sort of double-relation I identified in my two informants' use of the term "quality". However, the interpretive schema available to readers is blurred by the apparent objectivity of the text (as opposed to the "located" utterances of the nurses I interviewed). Thus, in this publication, the meaning of quality is blended and blurred. It calls up *both* the interpretive schema of an individual nurse's accountability for the provision of "quality care" to an individual patient *and* the managerial (cost-oriented) use and interpretation of quality, accountability and effectiveness, as though they are the same. Patient Centred Care, an industrial method of improving productivity (Gustafson, 2000; Armstrong and Armstrong, 1996), is aligned, in language, to the sense making practices of nurses. The language is converged and an illusion is created. By partaking in the same language, managers interested in cost-control and strategic planning and nurses interested in ensuring their patients receive proper care, appear to be referencing the same ideas and practices, which is not the case.

Alternate Level of Care (ALC)

ALC is an example of a practice of the transformation of business language *into* nursing language, an occasion of the evolution of nurses' speech genre. Alternate Level of Care (ALC) the new business-oriented diagnosis (discussed previously in Chapters Four and Five) is a term that, used by nurses, carries its historical production of meaning (from its home in management practices and the speech genre of business) into the social acts of nurses.

An illusion, similar to those accomplished in the terms "quality" and "patient centred care", is produced with the use of the term ALC. However, unlike the terms "patient centred care" and "quality", the category "ALC" *originates* as a cost-oriented term. It has no previous "home" in nursing. It arises within, and expresses the working relations of, health management and hospital restructuring. When inserted into texts used by nurses it becomes their word and *is shaped by the sense making practices of nurses.*

In Chapter Five I explicated how nurses in direct practice take up the term "ALC" through an interpretive schema related to what they know about the needs of dependent elderly patients. My interviews with nurses revealed how nurses used "ALC" as a gerontological term, a diagnosis, which, despite fitting the interpretive schema of a clinical "nursing" framework, did not actually advance nursing work in the interests of elderly patients. Nurses readily aligned themselves with the perception that, as members of an acute care team, they did not have time to care for frail elderly people. My interviews with front-line-nurse-leaders and people working in decision management revealed how, at this organizational location, ALC is used to "get a handle on who is taking up the beds". My observations showed that the strategic term ALC is located in two intersecting sites of activity. Action is taken by nurses who have been directed to initiate the ALC forms, but who also "use" the diagnosis to inform aspects of their clinical practice (They have learned they can bypass some clinical activities with ALC designated patients). Managers, who use the ALC statistics to make decisions about resource allocation, also take action. ALC draws nurses' activities into the organized purview of management technologies (reorganizing bed designations and staffing mixes).

In the mouths and hands of nurses, ALC *accomplishes* managerial work. Captured within the ideological code of efficiency nurses appear positioned to take up the conjoined terms of business and nursing without difficulty. When this happens, nurses' practices are governed by the cost-orientation that the language of ALC and Patient Centred Care are designed to produce.

Institutional ethnographers following Smith (1990a, 1990b) are guided to analyze social acts (such as the ALC work of nurses-in-direct-practice) as ideological practices, drawing attention to the how ideology is not only an intellectual phenomenon but is manifest in the activities of people. In this case, nurses' activation of ALC, and their interpretation of the re-engineered work design introduced as Patient Centred Care, contributes to accomplishing the (ruling) business-like, cost-oriented goals of hospital restructuring. They are practices that are not based in nurses' own knowing about the complex and intricate care required by frail elderly people, or the challenge of individualizing (centering) care to each patient's unique context. Rather, they are practices that are organized by a ruling, managerial perspective.

My analysis opens up for scrutiny how language works to imprint the managerial interest in cost-orientation *inside* nursing practices, and how it takes place without nurses knowing it. The language use of the evolving (blended) speech genre contributes to new professional practices. A new interpretation of "competent" nursing is being shaped that not only holds, but also promotes, nurses' cost-orientation and overrules other nursing

considerations. Nurses begin to "know" their patients through the knowledge practices of the managerial technologies.

A conjoined language of business and nursing is activated in nurses' professional publications (the T-discourse) [47]

Nurses' professional literature both directs and authorizes the blending and blurring of nursing and managerial speech genres. I discovered in nurses' texts that a redefinition of what nurses are to understand as "good nursing" is reinforced and stabilized. The nursing practices that are organized through workplace re-structuring strategies I have been describing – ADT, ALC, Patient Centred Care, bed utilization, patient satisfaction and so forth – are replicated in the accounts and directions for an "optimal" nursing practice found in nurses' professional literature.

In order to bring attention to the distinctive capacity of *texts* in the social relations of "discourse" Smith (1999) refers to the Text-discourse or the T-discourse. She writes:

> Conceive of discourses that are mediated by texts (I shall call these T-discourses), not as culture, meanings, significations or chains of significations, or texts without located readers, but as skeins of social relations mediated and organized textually, connecting and coordinating the activities whose local sites of reading/hearing/viewing may be geographically and temporally dispersed and institutionally various . . . People enter into practices ordered by the texts of the T-discourse and are active participants in its relations (p. 158).

Nurses' evolving professional T-discourse is a constituent of the social relations that connect and coordinate the activities of nursing. An expectation of nurses' professional practice is that they read professional literature and use it to inform and make sense of their nursing work. Nurses' T-discourse utilizes how nurses have been trained to

conceptually articulate the real world of patients and suffering, with nurses' professional standards, code of ethics, regulatory practices and so forth. Nurses, fluent in the double relations of the language, competent in conceptualizing their practice and imbued with the ideological code of efficiency knowledgably *activate* the efficiency practices that the contemporary professional discourse directs.

The language use and ideas of health care reform and hospital restructuring permeate the interpretive schema nurses use both to write and to read their professional publications. Nurses publishing in nurses' professional journals are caught up in the pervasive dominance of reform's cost-orientation. Unless the T-discourse is critically analyzed, the directions it offers nurses about how to improve hospital efficiencies are not readily discernable.

I proceed to analyze two texts circulating as nurses' T-discourse. The two texts came readily to hand. One is from the *Canadian Nurse*, a journal to which nurses are automatically subscribed when they register to practise nursing in Canada. The other I have used as an assigned reading for student nurses in the second year of the program I teach in. I use a line-by-line analysis, (a technique used by Smith (1990b, 1999)) to uncover how the texts, and the interpretive schema they instruct "work".

"Surgical liaison nurses embrace the family as part of the seamless continuum of care and holistic nursing practice"

Nurses in Halifax, Nova Scotia, wrote the first text I analyze. It is about a new job for nurses that enhances the care given to family members. The authors (Fowlie, Francis and Russel, 2000), all employed in nurse management positions at the Victoria General Hospital, write about how they solved a pervasive problem within the hospital's ambulatory care program. The initiative they write about was the creation of a new nursing position known as a surgical liaison nurse (SLN). The work of surgical liaison nurses does not involve them in the physical care of patients, rather, the SLNs provide a "communication link" informing and supporting patients and families before, during, and after the surgical date. It solved the problem of nursing staff not having time to talk to the families of patients undergoing surgery in the new "efficient" day surgery program. In this paper, the authors "utter" the new "conjoined" language genre (nursing and business) to build nursing knowledge about how nursing is to be conducted within efficient hospital programs. Readers are positioned *not to see* the programs themselves (other than as a successful and taken-for-granted accomplishment of the production of contemporary hospital care). Competent nurse readers learn how nursing practices are adapted to produce a new conception of good "quality" care.

The article, published in the *Canadian Nurse* is titled *A perioperative communication link with families* (Fowlie, Francis and Russel, 2000). The article begins with a 'headline":

> *1-01* In one Halifax hospital, a surgical liaison nurse embraces the family
>
> *1-02* as part of the continuum of care and promotes holistic nursing
>
> *1-03* practice" (p. 30).

It is ostensibly an article about "family nursing", "holistic practice" and a "seamless continuum of care". As a nurse, (and as one who has been involved in the hospitalization of a family member where I was far from "embraced") I am immediately captured by the potential benefits these authors are suggesting. I am interested in nursing approaches that attend to the needs and worries of families.

What my "normative order" of reading (both as a nurse and as a family member) drops away is the *restructured context* in which a new role for a perioperative nurse might make sense. Early in the article the authors promote the broad scope of the surgical program they are writing about which, through regionalization, is being administered over two hospital sites. Fowlie et al. (2000) explain how the same-day-admit and day-surgeries account for "85-95% of the surgeries done at the Victoria General (site)" (p. 30). The overall reduction of length of stay (LOS) of patients in Canadian hospitals – a key goal in restructuring .– has been accomplished through same-day admit and day-surgery programs.[48] The authors rely on their nurse readers not only to recognize and understand the programs they refer to but to accept them as one of the major "improvements" in hospitalized care, which have been shown to improve efficiencies, reduce costs and shorten waiting lists.

In this article, the nurses writing about the surgical program at the Halifax hospital do not draw attention to same-day admissions or day-care surgeries as *efficiency practices*. Rather, the focus they bring leaves the programs behind and firmly carries nurse readers'

attention to the interests of patients and families conceptualized as "communication" problems. The authors write:

> *1-04* We recognized that in the growing same-day-admit and day-surgery
> *1-05* programs, there was a lack of communication between the
> *1-06* perioperative team and families. For example, family members were
> *1-07* often left alone for hours with no information about the patient. As a
> *1-08* result they would stop any professional they saw in the hallways for
> *1-09* information. Families were both concerned and frustrated because
> *1-10* they did not know what was happening during the operation.
> *1-11* Anesthetists and nurses transporting patients to the post-anesthetic
> *1-12* care unit had to make their way around the worried family members
> *1-13* of other patients in the hallways. When uninformed family members
> *1-14* went to the post-recovery lounge to enquire about the patient, the
> *1-15* same-day-admit staff interrupted their nursing care of other patients
> *1-16* to meet the families' needs (p. 31).

The text organizes competent nurse readers to call up families' worries, concerns and frustrations. That the practices of the same-day-admit and day surgery are creating the problems does not surface in these authors' rendition. The programs are a "given". Nurses are expected to creatively develop new skills and new roles that adapt to the demands of the programs. Indeed, that the very programs creating the problems are growing (line 1-04) is not a topic for analysis or critique. For nurses, ambulatory care programs have become part of the everyday/everynight context of a hospital practice. Nurse readers, reading about the initiative for the surgical liaison nurse, can skim over this taken-for-granted background. Competent nurse readers can be relied upon to focus

on the benefits of a new nursing role that has been developed to provide a more holistic practice.

Concern about family members' frustrations and worries is painted over another commanding backdrop, in which competent nurse readers use the interpretive context of their experiences in restructured hospitals to recognize how family concerns interrupt the smooth rolling out of the ambulatory surgical program. For example, in Chapter Two I described Windle's (1994) care pathway for post anesthetic recovery where the patient's length of stay is divided into half hour time intervals and nursing intervention is directed minute by minute. Proficient nurse readers, who have first hand knowledge about nurses' rationed use of time in restructured hospitals, understand the problems (inefficiencies) that arise when their care is interrupted by families who would "stop any professional they saw in the hallways for information (1-08); or when "nurses transporting patients to the post-anesthetic care unit had to make their way around the worried family members of other patients in the hallways" (1-11); or how precious nursing time is "wasted" when the "same-day-admit staff interrupted their nursing care of other patients to meet the families' needs" (1-12). In Halifax, interruptions by families interfere with the tightly organized movement of patients in and out of ambulatory care. However, in this article about the SLN, the practical challenges nurses face in the "same-day" surgical production-line are *not* the dominant frame of reference the authors are calling up.

Beyond, and even more important than the authors' promotion of the restructured surgical care (as a powerful backdrop), is the authors' attention to family concerns and

worries and how these are important issues for nurses to address through enhanced communication. The traditional speech genre of nursing – "lack of communication between the perioperative team and families" (1-06) and "families were both concerned and frustrated" (1-09) – positions nurse readers to call up a nursing frame of reference (the needs and care of patients and their families). The unqualified promotion of cost-oriented efficiencies (through restructured programs) and managerial approaches to dealing with inefficiencies (strategies to reduce the interruptions created by worried families) are glossed over. They are carried invisibly within a converged language that references "embracing the family as part of the continuum of care to promote holistic nursing practice" (1-01 - 1-02). Readers (and, within the pervasive reflexivity of nurses' social world, the authors, too) are positioned to see only a successful strategy to address the frustrations and worries of families, the "legitimate" purview of nurses' interests.

Fowlie et al. describe how the (new) role of the surgical liaison nurse

> *1-17* was developed as a *quality improvement initiative* with the
> *1-18* intent of providing a communication support and comfort link with
> *1-19* families of surgical patients (p. 30, italics mine).

That the quality improvement program is part of the (ruling) managerial strategy to improve efficiencies is subsumed when it is aligned with words such as "comfort link" and "communication support". The double relation of the term "quality" is being used as a crossover link between nurses and managers. The language of "quality" – "mission statements", "objectives", "project team", "evaluation strategies" and references to the efficiencies realized through the "growing same-day admit and day-surgery programs that

account for 85-95% of the 30,000 surgeries performed" (p. 31) – reside along-side words and phrases such as: "alleviating anxiety"; "support"; "focusing on family"; "holistic health care"; and "comfort". The language employed blends the speech genre of management, the business language of "quality improvement", with the traditional speech genre of professional nursing.

The new role of the Surgical Liaison Nurse implemented within technologies of "quality management" is also linked to text-based accountability practices. The administrators who initiated the SLN program distributed questionnaires to staff and to family members to evaluate the new program. They included several of the questionnaire responses in their paper:

> *1-20* "Finally, in our world of cutbacks there is a role that truly benefits the family".
>
> *1-21* "I have witnessed on numerous occasions a sigh of relief when family members are informed that someone will be available to touch base with them".
>
> *1-22* "What a comfort to have someone to answer questions and reassure me that all was going well".
>
> *1-23* "A wonderful system – makes you feel that your loved one is in good hands".
>
> *1-24* "Programs such as these should be enhanced and maintained. Personal contact and dialogue are sadly lacking in health care these days".
>
> *1-25* "Information has a calming effect on family members".
>
> *1-26* "The person in this position (the Surgical Liaison Nurse) has an incredible opportunity to make a real difference for the people's experience. It is a highly educational role, but offers a supportive caring face to what can be an isolating experience".
>
> *1-27* "My compliments to one of the most progressive changes I have seen in health care for years" (p. 33).

In these staff and patient endorsements, the syntactical arrangement of the comments reveals how we (and they), as readers and co-actors of reform are authorized to overlook the fundamental negative impact of reforms on patients and staff – "finally in our world of cutbacks" (1-20); "Personal contact and dialogue are sadly lacking in health care these days"(1-24); "what can be an isolating experience" (1-26); "one of the most progressive changes I have seen in health care for years" (1-27) – instead, this paper organizes readers (as the SLN program and its evaluation text organizes nurses and patients) to interpret the SLN role as a "caring face, a "progressive change" and a "calming effect".

Fowlie et al.'s (2000) initiative is organized through and through, by the adoption of cost-oriented business strategies. These strategies produce the taken-for-granted conditions that nurses, (and the authors) through their activation of the ideological code of efficiency, are organized to gloss-over. Nurses "read" their own practice problems within their new speech genre which has been infected by the conjoining of business and nursing terms. Unless the text is critically analyzed, the directions it offers to nurses about how to improve hospital efficiencies are not discernable. Nurses are positioned to respond to the sense making practices of the ideological code and to participate in the relations and practices it orders while nurses' language use, both in speech and in texts, creates an illusory "fit" between nurses' traditional interests and their new efficiency practices.

These practices of reading eliminate nurses' grounds for rebuttal and resistance. Nurse readers, accustomed to "skimming over" the assumptions of fiscal restraint and the new

programs that are being organized through managerial technologies, are guided to reference only nurses' "traditional interests". For nurses caught up within the practical exigencies of reform and restraint, the development of a new, expanded, interdisciplinary surgical liaison nurse role is welcomed as a helpful resource. Through the double relation of words and via syntactical arrangement of language (using business words along side the altruistic language of nursing), the actuality of what is happening to nursing practices in restructured hospitals is suppressed. At the same time, this "sleight of language" advances nursing support for new efficiency practices (solving the problem of interruptions through SLNs) under the guise of "good nursing".

"Maximizing time, minimizing suffering: The 15-minute (or less) family interview"

In contrast to the previous two nursing texts I cited (Sandu, Duquette and Kérouac ,1992; Fowlie, Francis and Russel, 2000) that were written by nurse managers employed in hospitals, the following text (Wright and Leahy 1999) is written by two nurse scholars affiliated with the University of Calgary. Nurse scholars too are caught up by the ideological code of efficiency and the conjoined language and evolving speech genre of business-like nursing. Wright and Leahy are presumably *not* subject to the pressures of running hospital programs. Nonetheless, despite apparently being in an "objective" position, removed from the daily pressures of moving patients in and out of hospitals, Wright and Leahy are captured by the characteristic usage of a business-like, cost-oriented language. They too are captured by pervasive beliefs about the inevitability of reform and restructuring. The following textual exhibit re-emphasizes how nurses'

training in theoretical and conceptual thinking enable them to use a conjoined language to make sense of their real work with patients' (actual bodies with actual families) and articulate it with the nursing discourse.

Wright and Leahy's publication is clearly based in nursing scholarship. Unlike the *Canadian Nurse* where Fowlie et al. (2000) published, *The Journal of Family Nursing* is a refereed journal. The article by Wright and Leahy claims to provide "essential knowledge of sound family assessment and intervention models, interviewing skills and questions" (p. 259). The authors are well respected in the field of Canadian family nursing. They reference their own Calgary Family Assessment Model which they describe as an "integrated, multidimensional framework based on the systems, cybernetics, communication, and change theoretical foundations" (Wright and Leahy, 2000, p. 67). Their paper offers directions to nurses for how to include the family in therapeutic interaction. The "key ingredients" of their framework (manners, therapeutic conversation, family genogram and commendations), offer strategies for how nurses are to conduct "family nursing" in the hospital setting.

On the surface of this text, it appears the focus of nurses' work is to "alleviate and diminish suffering" (p. 261). What my analysis shows is how the instructions for fiscal reform are latently active and affect nurses' work, if invisibly. The ideological code of efficiency is almost entirely recessive in this scholarly appeal to nurses to attend to the needs of families. Unintentionally, perhaps, the authors activate nurses' efficiency practices in the form of "brief interviews" that "involve families". Unwittingly, their

instructions shift increasing responsibility to the unpaid care-giving work of families. These "volunteer" caregivers (predominantly women) are relied upon to provide the informal nursing care, at home, that hospital restructuring depends upon.

In this article, the ideological code of cost containment (budgetary constraints and staff cutbacks) is invoked in the first two paragraphs; it is explicitly made available to function as an interpretive schema. In nurses' reformed work places, nurses no longer have time to talk to the family members of their patients:

> *2-01* Time is of the essence in nursing practice. Major changes in the
> *2-02* delivery of health care services through budgetary constraints and
> *2-03* staff cutbacks have required new ideas for involving families. Rather
> *2-04* than excluding family members from health care, more efficient
> *2-05* ways need to be determined of how to conduct brief family
> *2-06* interviews (p. 260).

Here, the ideological code organizes nurses to accept budgetary restraints unproblematically (2-02). The authors' instructions to nurses – "rather than excluding family members from health care, more efficient ways need to be determined"(2-04) .– reveal that they too have been "infected" by the ideological code.

The authors provide readers with a set of directions (the interpretive schema) for how the ensuing construction of "good nursing" is to be read. It emphasizes that "good nursing" requires "new ideas" directing nurses' to re-think old, apparently inefficient practices. The authors write:

2-06 "I don't have time to do family interviews" is the most common
207 reason offered by nurses for not routinely involving families in their
2-08 practice. In numerous workshops and presentations, we
2-09 encountered this statement as the resounding declaration for the
2-10 exclusion of family members from health care. For nurses'
2-11 behaviors to change, they must first alter or modify their beliefs
2-12 about involving family members in health care. We have discovered
2-13 that when nurses do not involve family members in their practice,
2-14 some very constraining beliefs usually exist (Wright, Watson & Bell, 1996).
2-15 Some of these beliefs are: "If I talk to family members I
2-16 won't have time to complete my other nursing responsibilities"; "If I
2-17 talk to family members, I may open up a can of worms and I will
2-18 have not time to deal with it"; "It's not my job to talk with families,
2-19 that's for social workers and psychologists"; "I can't possibly help
2-20 families in the brief time I will be caring for them" (p. 260).

For the authors, nurses' exclusion of family members is due to "constraining beliefs" (2-13.– 2-14) and nurses' lack of knowledge about "efficient ways to conduct brief family interviews" (2-04.– 2-05). "Staff cutbacks and budgetary restraints" (2-02.– 2-03) that organize nurses' practice are not criticized – they are a *taken-for-granted* accomplishment. They require nurses to develop new strategies. Also taken-for-granted is an expectation of how, in the face of reforms, "good nurses" will adapt their practices to become more "efficient". This blurs – for both nurses and the public – how the conditions within which nursing is done have changed drastically. It creates the illusion that nurses themselves can maintain an unchanged quality of nursing service if only they change their old-fashioned beliefs and practices.

As the authors continue (2-21.– 2-35 below), their conceptualized version that "good nursing" requires accepting new ideas about families is reinforced. Note how the authors continue to advance nurses' professional, altruistic discourse. The authors propose:

> *2-21* Uncovering these constraining beliefs makes it more comprehensible
> *2-22* why nurses might shy away from routinely involving families in
> *2-23* nursing practice. We postulate that if nurses were to embrace only
> *2-24* one belief that "illness is a family affair" (Wright et al., 1996, p. 288),
> *2-25* it would change the face of nursing practice. Nurses would then be
> *2-26* more eager to know how to involve and assist family members in the
> *2-27* care of their loved one. They would appreciate that everyone in a
> *2-28* family experiences an illness and that no one family member "has"
> *2-29* diabetes, multiple sclerosis, or cancer. By embracing this belief, they
> *2-30* would realize that from initial onset of symptoms, through diagnosis
> *2-31* and treatment, all family members are influenced by and reciprocally
> *2-32* influence the illness. They also would come to experience how our
> *2-33* privileged conversations with patients and their families about their
> *2-34* illness experiences can contribute dramatically to healing and the
> *2-35* diminishing or alleviation of suffering (p. 160).

The organizing features of the actual work being done by nurses with family members (in the restructured settings) are glossed over as nurses' "constraining beliefs". Recall how my informant Nurse Rushing told me:

> She (the patient's wife) arrives and I introduce myself and I'm trying to figure out who she has already talked to, and I'm trying to slow down so that I can give her all this information in a way that won't be too overwhelming, I am rushing though, through the discharge instructions, the prescriptions, his bowel meds and stuff. So I'm talking to her, explaining about his incontinence and telling her where she can buy Attends (adult diapers).

Nurse Rushing did not need Wright and Leahy to point out that her patient's wife was "influenced by and reciprocally influenced the illness" (2-31– 2-32), nor the need for brevity. In this nurses' practical reality, the material features of her work produced the "brief family interview" she conducted. Nonetheless, this nurse's practices and concern for her patient's elderly wife, align her with Wright and Leahy's authoritative discursive instructions to nurses. The material features of what actually happens between nurses and patients, such as the ad hoc advice to purchase adult diapers and the attempt to put in more home supports, is unavailable in the authoritative discourse that represents competent family nursing practices. Nevertheless, the discourse sanctions the adaptations nurses make in order to produce a more efficient (cost-oriented) practice.

Hidden in Wright and Leahy's (1999) theorized contemporary nursing interest in "family nursing", is how the authors' construction of an "ideal" nursing practice which uses language such as "embracing the belief that illness is a family affair" (2-23 – 2-24) concurrently aligns its nurse readers with the fiscal interests of health care reform and hospital restructuring. As I have identified throughout this dissertation, nurses' involvement in high pressured discharge/bed utilization work always involves families. Wright and Leahy's strategies to involve family members is "bed utilization work". Mediated through a conjoined language of "budgetary constraints", "embracing the family" and "brief family interviews", nursing activities, such as developing discharge-planning-flow sheets and "getting the families on board early", become the new and desired practices of proficient nurses.

Conjoining a nursing language that calls upon nurses' moral vocation to "contribute dramatically to healing and the diminishing or alleviation of suffering" (2-35); and to "engage in privileged conversations with patients and their families" (2-33) with instructions for "brief fifteen minute interviews" is one more way in which nurses' consciousness – their knowledge about nursing – is colonized with the managerial perspective. In this example from nurses' *academic professional T-discourse*, the new business-like cost-orientation through which nurses are organized to practice is dropped out of sight. Through language, the ruling relation of business-like efficiencies is justified and buttressed by the expression (in language) of nurses' traditional professional interests. The language used conjoins nursing interests with those of health care reformers for whom costs and cost-control are the dominant and ruling interests.

Chapter seven conclusion

My interrogation in this chapter has focused on nurses' language and the text-mediated intersections of business management, health management and professional nursing discourses. Bakhtin (1986) writes:

> In order to puzzle out the complex historical dynamics of these systems (of language) and move from a simple (and, in the majority of cases superficial) description of styles, which are always in evidence and alternating with one another, to a historical explanation of these changes, one must develop a special history of speech genres that reflects more directly clearly and flexibly all the changes taking place in social life. Utterances and their types, that is speech genres, are the drive belts from the history of society to the history of language (p. 65).

Nurses' social life is being restructured. Within the historicity of the social restructuring, accomplished through the implementation of new efficiency practices, nursing discourse is also being restructured. A new speech genre is evolving. In this new speech genre

managers "pick-up" terms from the conceptual jurisdiction of the traditional professional nursing genre and nurses employ terms from the genre of business management. Nurses' altruistic language – "the essence of nursing" (1-18); "quality interactions" (1-24); "nurses' caring" (1-29); "the well-being of patients" (1-36); "comprehensive continuum of care" (2-02); "communication support" (2-20); "embracing the family" (2-29); "privileged conversations" (2-33); "making a difference" (2-34); "diminishing and alleviating suffering" (2-35); and so forth – provide the syntactical links and the "double relation" that when interpreted beside references to "growing same-day admit and day-surgery programs that account for 85-95% of the 30,000 surgeries performed" (Fowlie, Francis and Russel, 2000, p. 31) and phrases such as "quality improvement initiative" (1-19); "time is of the essence" (2-01); and "budgetary constraints" (2-02) – produce a new speech genre. A conceptual language is being developed that managers and nurses can share "in-common". Its use carries with it, and expresses, the ruling relation of business interests. Nurses fluent in the ideological code of efficiency/debt/deficit are captured by the new genre. It orders nurses' restructured interpretive schema through which they produce the "ideological practices" (Smith, 1990a, 1990b) of the restructured hospital workplace. What emerges are disquieting contradictions for contemporary nursing. These contradictions are evident in the everyday practices of nurses and they also emerge in the professional discourse. The profession now speaks the language of restructuring as its language. It promotes "efficiency" (with all its ties to costs, economics and capital accumulation) as a nursing value. As seen in the nursing texts analyzed here, the range of negative consequences is not ignored. Rather, they are treated as something to be managed. Nurses are taught to "read past" the socially organized conditions of health

care reform that account for the negative impacts on them, their practices, and their patients.

Conclusion

Throughout this dissertation I have argued that health care reform and hospital restructuring are deleteriously affecting nursing work. Managerial technologies (standardized programs for bed utilization and the like) are expected to lead to health care being managed more precisely and more effectively – reforming it. While health care is being reformed for efficiencies, expectations about what nurses do with, and for, patients in hospitals remain high. Nursing care, if not actually improved, is assumed to be unfettered by the reforms. I have shown in many instances, that what nurses do for their patients *is* being re-formed, but in troubling ways. In this dissertation I am both analysing and making a critique of what I see as this organizational agenda for business-oriented efficiencies permeating (and disrupting) the practice of nursing and the nursing profession.

I argue that nurses working in hospitals are hooked into restructuring efforts through the textual practices that infuse their work in everyday ways. I have described nurses working with Quality Assurance forms (QA's), bed-maps, Alternate Level of Care (ALC) texts, clinical pathways and discharge planning flow sheets. In the absence of a critical analysis, these textual systems being used in hospitals appear to be specific to local needs, just neutral tools that help nurses get their work done. By tracking and analysing a few instances of the plethora of textual practices that hook nurses into hospital restructuring, I show them to be part of a more widespread practice. I have argued that the managerial and accounting procedures being generated across local hospital sites regularly converge into information that is "centralized", and that circles back to be used

in regulatory decision making processes. That is, of course, its reformative potential. My analysis illuminating the materiality of texts and activities across local sites, which I track into the politico-administrative regime of reform, is generalizable. Through my analysis, I have been able to identify and explicate how these managerial technologies are part of the social relations of ruling in the Canadian health care system.

Throughout, I have pointed out the *ruling effects* of numerically-based, categorized, descriptions of health care that are based in information technologies. I have pointed out the less progressive side of reforms that are accomplished through a reliance on the "good" data that is created using these sorts of systems. I recognize that my argument goes against the grain of contemporary thinking about how to improve the Canadian health care system. My vehement critique of these sorts of systems puts me at risk for being criticized as a twenty-first century Luddite, strongly opposed to the use of technological data banks and the "information highways" of our time. This is not the case. I am not recommending a social action such as those of the English workmen of the eighteenth century, who banded together to prevent industrialization by wrecking factories and machinery. Rather, I am suggesting that, as a ruling relation, these sorts of knowledge systems have been proceeding essentially uncontested. It is that, almost blind acceptance, that worries me. I argue that their use in Canadian health care management constitutes a powerful form of control that overrides and displaces other useful knowledge and insight. I am very concerned about the hyper reality these systems generate and its *particular* description of what is happening in health care. These systems reroute the capacity for authoritative decision making away from local

participants The technological systems consistently subordinate the knowledge and experience of actual people. Despite what I see as significant limitations, the technologically produced knowledge systems are being used as a powerful regulator.

Here is what I have found. The hyper realities that the technological systems generate are used to track and aggregate elements of patients' and nurses' activities. They are forms of managerial knowledge that get treated *as if* they were actualities. I have argued that what is actually happening to patients and nursing practices is both organized by, and subordinated to, the hyper reality of numerically-based aggregates and standardized systems. The dissertation sets out in detail many instances of nurses and their managers making "knowledge-based" decisions based on this hyper reality. Managerial technologies such as the Admission Discharge Transfer (ADT) system, patient satisfaction, and Alternate Level of Care (ALC), vested in texts, direct nurses' attention to *particular elements* of patient care that serve the organizational interests in costs and productivity. Within this hyper reality a particular knowledge of hospital care is constructed – one that focuses on "efficiency". My most serious critique is that "efficiency", as constituted in managerial texts, overwhelms knowledge of patients as whole people. Patients known in this hyper real manner become objects of managerial and professional action. Nurses participate in building and using this knowledge, and it comes to dominate their thinking and action.

My analysis focuses on how this happens. I have discovered that the way nursing itself is managed in contemporary hospitals relies on reframing and reconstituting nursing

knowledge – what nurses "know". But the restructuring of nursing knowledge does not follow hospital restructuring as night follows day. Nurses are not docile creatures easily persuaded to change their ways. In order to teach nurses their "new" knowledge, and to ensure that nurses participate competently in activities that allow various new institutional manoeuvres to be made, various managerial and professional strategies have been adopted. These strategies enforce nurses' rationalization of, and compliance with, their new efficiency oriented activities. Thus, it is my contention that the information technologies and managerial practices that re-structure hospitals also re-structure nursing knowledge and nurses' consciousness. Nurses learn how to address their problems at work from a managerial standpoint, shaped by the cost-oriented efficiency commitments of hospital administration, as they go about their restructuring activities.

Nurses are held to actions that comply with the restructuring efforts. Bed pressures are organized through systems that speed up, standardize, and ration nurses' work with patients. Nurses are coached and monitored to attend to efficiency practices by a corps of "head nurses" whose work and titles have been explicitly restructured. The new front-line-nurse-leaders are stationed at the centre of nurses' efficiency practices. They become charged with monitoring front-line productivity practices and are held (personally) accountable for efficient bed/resource utilization. Their role of clinical support has been subordinated by their restructured efficiency work.

Some of the strategies implemented to enforce nurses' compliance to the administrative/managerial ruling regime are technological and/or supervisory in form and

are implemented in hospital workplaces. A less direct and subtler influence on nurses is the incursion of managerial thinking into the nursing discourse. Nurses' language and conceptions are being blended with managerial language and conceptions. It is my contention that a distortion of nurses' beliefs and values is taking place, masked within a nursing discourse that is evolving an illusory double-sided language. I have analyzed how nurses' use of this double-sided language is having a peculiar effect on nursing practice. The new professional language produces a duplicity that both generates and covers over nurses' participation in the business-oriented enterprise of hospital reform.

As individuals, nurses work within, and recognize all too well, the difficult conditions that health care reform is expected to improve. They are frequently keen supporters of new strategies (that arise in, and are expressed by, the double-sided language) to get at inefficiencies. Individual nurses struggle to maintain their own level of excellence in practice. Yet their participation in restructured hospital activities means that, as part of their work, they adopt the associated language that imperceptibly carries them away from their standpoint of caring for patients, and sweeps them into accepting the management standpoint of organizational efficiency. Speaking its language, they learn to accept its interests as theirs. The new managerially-oriented discourse of nursing professionalism supports this re-orientation.

Socialized and trained to care for people, nurses must now "nurse" the organization. "Nursing the organization" is professionally sanctioned by nurses' use of particular words, discursively formulated at authorized sites of nurses' reading and writing. The

language provides the discursive terrain in which nurses can "speak good nursing" while practicing something else. The professional language of nursing constructs a kind of idealized image of itself, to which its members must try to conform, while it imperceptibly builds and justifies nurses' cost-oriented efficiency practices.

I have explained how I understand this serious contradiction being generated for nurses. My analysis identifies how text-based nursing management methods and the professional nursing discourse are ideological; that is, they construct nurses' own knowing about nursing, about patients, about organizational practices in line with beliefs about rampant inefficiency and the need for better management as a solution to the problems in contemporary health care. Accordingly, nurses build their practices ideologically, as they activate the various texts. That is, nurses come to organize their thinking, their work with patients, with other staff, and with the institution, in alignment with the dominant ideas of hospital restructuring. The organizational focus of efficiency exploits nurses, and their skills and commitments to patients, using nurses' caring and energy for goals that favour cost-saving over patients' needs. The benefits of nursing work, for Canadians, traditionally performed within a common goal of meeting the health needs of the people, is being lost or at least attenuated.

The analysis I have developed throughout this dissertation goes some way toward undermining the taken-for-granted trust in "evidence-based" information being generated to manage health care. While some nurses currently contest the hyper reality of improved, more efficient hospital care, increasingly, my analysis suggests that those

voices are being or will be dimmed. Nurses are being coached and expected to exclusively trust the "facts" and "truths" generated through management information systems. Even though, under scrutiny, nurses' talk, observations, and activities are incongruent with certain aspects of the "knowledge" about the improvements achieved in hospitals and professional nursing practices, any dissension is overruled by the powerful systems of control held by the incontestable documentary evidence. The authority generated by health information systems such as the ones I have analyzed, and revealed as flawed, is however, becoming incontrovertible. Contributions nurses might make from their experience-based knowledge and judgement are being subordinated to the hegemony of hospital management technologies and the systems of enforcement I have described. This is the basis for my claim that nurses' own working knowledge about patients and patients' needs is being colonized by a managerial framework of "knowing" that is also colonizing the "body of knowledge" that is nurses' professional discourse.

What does this mean for nurses and to the profession of nursing?

Even when nurses accept the requirement to develop more efficient ways to nurse patients and to act within the managerial mandate (which many nurses do, and all are encouraged to do), the outcome is a troubled workforce. Nurses are wedged in a place of discomfort between the conflicting expectations of organizational efficiency and their commitment to patients while "looking into their eyes".[49] Throughout the decades of reform and restructuring, many of the reasons patients look to nurses and to nursing care have not changed. Despite changing medical tools and treatments, patients continue to experience things such as pain, breathlessness, nausea, and fever. They continue to

suffer, to feel vulnerable and to experience fear. Much of the embodied work nurses do to address their patients' needs cannot be captured by technological approaches currently relied upon to describe and account for contemporary health care. Nurses are caught in a disjuncture as they work to articulate the needs of people within a reformed system that has been redesigned to treat people and their needs as numbers and categories. They must reconfigure their practice to try to make the actualities of their work practices match the constructs of the managerial technologies.

Many nurses are perplexed. Despite what nurses are being told about the improvements, and the data that shows patients "doing well", there are many nurses in the system who know differently. What these nurses *really* know – from their everyday/everynight work– is at odds with their new, discursively organized, efficiency-oriented knowledge. Many of the nurses I spoke with questioned their ability to give "good care". I heard many stories of ordinary nursing care gone awry. For instance, I heard nurses talking about low urine outputs that were not reported; peri-pads on women who had undergone gynaecological surgeries that had not been assessed or changed for unacceptably long periods of time. Nurses discussed how they were noticing more mistakes in intravenous and medication therapies. According to the nurses I spoke to, early signs and symptoms of complications such as infection, of deep vein thrombosis, of compartment syndrome and so on, were being overlooked. Nurses described their frustrations related to the cost to them, and to their patients, of the organizational efforts to make ever penny count. That is how they saw "back transfers", by which they meant moving patients to emergency in the middle of the night to accommodate post-operative patients who are

admitted through the emergency room. Or of playing "musical beds" when patients are juggled from room to room (bed to bed) to reconfigure among private, semi-private, isolation rooms and so forth, to "make a bed". They described how their caring work has been infiltrated by numerous efficiency-oriented interruptions that distract them and leave them vulnerable to making mistakes. Experienced nurses, especially, talked about how "basic care" is no longer attended to. Bathing patients, mouth care, bowel care, looking after dentures, even the regular changing of bed linens, according to these nurses, is not being incorporated as part of nurses' routines. Nurses also tell stories about supplies running out, (linen, wheelchairs, geri-chairs, IV poles), they talk about equipment not working, beds and wheelchairs, suction and oxygen adaptors etc. malfunctioning. They talk about experiencing diminishing support from other departments (housekeeping, dietary, maintenance, laundry, pharmacy) in the new, more competitive, organizational environment. They complain about how "all the support services have voice-mail now, nurses are the only ones who ever actually answer the phone". In my participant observations of nurses at work, I observed nurses adapting, making do, cutting corners and coping with multiple demands and disruptions that resonated with what they are saying about the strained conditions of their work.

When nurses are unhappy and angry, they impugn particular people (front-line managers, middle managers, hospital executive staff, nursing teachers, government bureaucrats and politicians) for their current workplace/professional troubles. Nurses conclude that hospital administrators do not understand the issues, plan poorly, make poor decisions, drain valuable resources away from direct practice, do not value or respect workers in

direct care and are ultimately responsible for the daily/nightly troubles of nurses. Certainly, in the instance of the NUC activism, the problems in patient care raised by the nurses were construed (by both nurses and managers) as problems of individual competency and issues of interpersonal conflict. "Counselling" strategies were implemented to improve communications and relationships. Issues, such as those raised by the nurses of NUC, are also met by calls for more accountability. Such calls are addressed by more reviews, reports and apparently closer scrutiny of hospital practices, such as those recommended by the Romanow Commission (2002).

Conflict Management and Accountability: Questions for future study

Conflict

According to the logic of health care reform and hospital restructuring, nurses' "bad temper" and the ensuing "conflict" that develops needs also to be managed in the abstract manner I have been analysing. A new trend in what many are calling "the new public management" (McCoy, 2001) focuses on "interpersonal conflict" (Gervase, 2001; Annis Hammond, 1998; Short, 1998; Weisinger, 1998). Knowledge about "the trouble with nurses" becomes a management responsibility to define – like "efficiency" is defined – to be addressed within the approach to managing that advances the organizational interests. Thus framed, nurses' truculence becomes something that is addressed by strategies of conflict resolution, and through programs designed to foster leadership skills and team building. Strategies are being implemented that are directed towards "managing" nurses' *expression* of their frustrations and worries. Indeed, the recently reorganized Vancouver Island Health Authority (VIHA) has established a program of "Conflict Management". This is an initiative which will institutionalize how nurses (and their managers) are to

respond, not only to their troubling practices with patients, but to the "conflicts" that are generated when nurses' work with their patients fails to produce the (apparently) smooth efficiencies directed by the new technologies. These are the occasions when nurses' are overwhelmed by the demands of their patients and the demands of the organization; when nurses' new knowledge about discharges and bed utilization is not sufficient to align them with the ideological practices of efficiency. Nurses' agitation on these occasions, has itself, become something to be managed.

Clues about the new management strategies being implemented to address nurses' chafing bad temper were apparent in the NUC story I related at the outset of this dissertation. Recollect, from Chapter One, how the nurses meeting in one another's homes were angry about the lapses in patient care. When the NUC nurses escalated their political action to involve the local press they were asked to meet with the hospital president and executive director (who also met separately with the nurse managers). The executive director concluded, "the staff/management culture at the hospital was severely damaged" (Internal Memo, Executive director, 1998). A private consulting company was contracted to work with the nurses and their managers to "reach agreement on the kind of climate (behaviours) that will be supportive of raising, addressing and solving problems collaboratively" (Internal memo, Consulting group, 1998). I want nurses to ask: What is wrong with this picture?

I have shown how the effects of restructuring are an important component of the "conflict" that grips nurses. While nurses are keen to work efficiently, my analysis

shows that troubles are routinely created when efficiency itself is defined ideologically. In this regard, my analysis brings something else to the fore. It specifies the *actual practices* that are being organized by new approaches to the management of health services. Working empirically, I am able to capture those occasions when the socially organized disjuncture embedded in nurses' experience "chafes". My analysis locates the disjunctive (frequently taken-for-granted) activities that connect nurses into the broad social relations that regulate nursing work for managerial efficiencies, rather than for the good of individuals.

I can now critique more effectively the managerial logic that lies behind nurses having to frame their concerns about patient care inside "rules" about climate (behaviours) and collaboration. The problem that managers see, and want to solve, is how to get nurses to stay within the discursive frame for speaking about their troubles. It appears that nurses should not know patient care issues differently from how the managerial discourse generates the authoritative account of them. If there is a disjuncture in knowing, the authoritative version will be mobilized to subordinate knowledge about what actually happened (or is happening) as it is experienced and known by nurses-in-direct-practice.

My interest in (and critique of) managerial strategies that have been developed to contend with fractious or unhappy nurses was further piqued at a recent workshop I attended during a nursing clinical update conference (Nursing clinical update 2003, Nova Clinical Services). During this workshop the regional coordinator of VIHA's conflict management program discussed strategies that nurses' might employ for dealing with

"conflict in the workplace". She offered ideas for how nurses might "change their perceptions" about how they experience their workplace in order to "intelligently make use of emotions to guide behaviour" (Bowker, 2003). The audience participated in an exercise in which half of the group were asked to recall an incident/issue in their practice that was not well resolved, and the other half were to recall an incident/issue that had a satisfactory resolution. One nurse in the audience, visibly upset, described an unresolved work situation in which she and her colleague were being asked to accept more patients than they could safely manage. The coordinator of the conflict management program interrupted the nurses' account, saying, "I'm going to stop you now". The coordinator then pointed out how, when issues like this arise, nurses should avoid confrontation. Rather, they should work as a "team". A strategy was described that involved nurses adopting a "change methodology" that would assist them "to discover the aspects of the situation that were working and find more ways to do more of it" (Bowker, 2003). It was suggested that nurses should "change their perception of their problems, reframing them". It is at moments like this that I recognize that a managerial approach like this one will not answer such concerns as those raised by the nurse in this audience. The nurse who was recalling an unresolved issue in her work was asking to have her professional judgement included in the discussion. The managerial "new nursing leadership" (Krairiksh and Anthony, 2001) approach attempts to maintain the managerial perspective against any crack in the ideological formulation that might arise from seeing what was actually happening in the setting.

The restructuring agenda that I have been explicating through this dissertation puts issues, such as the one this nurse was expressing, into the arena of hyper reality. In the case of a nurse whose patient assignment has exceeded her capacity to provide care can be managerially linked into systems of bed allocation, workload indexing, and ultimately into systems that compare and standardize nurses' patient assignments across "peer" hospitals. At the same time, her resistance, should she continue to resist, can now be linked into institutionalized systems of conflict resolution. My analysis disrupts these methods of knowing and of decision-making. It offers nurses a way of understanding and authorizing their own practice-based knowledge. It asks for solutions that transcend the ideological and address the actuality.

It becomes clear that initiatives developed to address "climate", to manage "conflict" and to "change nurses' perception" are framed in such a manner as to prevent nurses (and managers) from understanding and acting on the actual circumstances of their troubles. But until the untoward effects of administrative reforms are chronicled and legitimated by research (such as the research I have undertaken here), which shows their social character, they will continue to be addressed ideologically, as problems of individual competency and attitude. And nurses will continue to be expected to understand them that way. My contribution reveals the actualities to which nurses are responding and it offers an alternative to blaming them for feeling conflicted.

Accountability

My analysis also makes an important contribution to the debate about accountability, such as the Romanow Commission's (2002) recommendations that call for increased

monitoring of health care and its administration. As I have been showing, there is a built-in flaw in methods of accountability that rely on the managerial work-up of the facts. "Knowing" is never neutral. Managerial accountability practices, formulating knowledge of health care within an orientation to control costs, offers a different view than the view that is available from, for instance, nurses' everyday/everynight location. Managerial knowing is abstract and constructed to fit ideological frames. Nurses' knowing, at least prior to their submersion in managerial technologies and the managerially infected professional discourse, is an embodied and empirical knowledge. As more abstracted accountability systems are put into place, knowing the health care system will rely more and more on the hyper reality. That hyper real knowledge is expressly framed by a business-orientation of health care as an "industry". As my analysis of patient satisfaction technologies demonstrates, systematic technologies relied upon to gauge accountability will paint a very partial (but ruling) picture of "what is actually happening" in nurses' everyday/everynight work. The essential problem with the ideological practices of accountability is that they are distanced and insulated from the peopled settings – where people fall ill, suffer accidents, recover or succumb. Their conceptualization, like that of the managerial information, is within the ruling frameworks. Accountability, too, is constructed as hyper reality.

Opening the social organization of hospital restructuring to a material interrogation reveals that the significant troubles nurses are experiencing arise explicitly out of the authorizing practices of the new public management. Even more revealing, is how the evolution of the nursing profession and its commitments, are being organized to match

the ideological practices of the new approach to managing health care. This dissertation has opened up to critical analysis how the new strategies to manage and regulate nurses and nursing restructure what can be known, authoritatively, about what is going on in hospitals. Nurses (bureaucrats, managers, educators, and nurses-in-direct-practice) who are persuaded by my argument must take a position as "critical sceptics". Nurses need to ask whose interests accountability practices serve and whose knowledge the numerically authoritative knowledge displaces?

The activities that I describe throughout this dissertation chronicle almost a decade of the unfolding events of hospital restructuring. Much of what has been accomplished during this time seems irrevocably entrenched – an impossible tide to turn back. Nurses' consciousness is well harnessed, the ideological code of efficiency is firmly entrenched, nurses' professional regulatory bodies are generating and using their own brand of abstracted knowledge-based technologies to regulate and monitor nursing practices. Nurses are being held to account for their part in the new managerial agenda. They are being expected to maintain their good humour about it all. Nonetheless, the chafing disjuncture produced by the inexorable unfolding of so-called hospital efficiency remains. It is in this disjunctive space that an analysis for resistance can begin, within the terrain of nurses' practical activity. It is here where possibilities for social action can be sparked – from the standpoint of nurses – in the interests of patients.

Implications for action

What this analysis produces is a way to "talk back" (Heap, 1995). It is an analysis that produces a return to the "common ground" of nurses' daily/nightly work lives, shared with others. It is a way of looking that produces a different understanding about how nurses' embodied local work is put together. I have contributed to a "map" of the social relations of nurses' work that has potential to be accessible and usable, an empirical ground from which to consider first, *how* things are organised against nurses and then, learning about that, how to proceed toward resistance.

For me personally, an important site of resistance is within nursing education. As a nursing instructor I reflect on the way nursing education creates new participants willing and able to contribute to the efficiency project. I see more clearly my own participation in the new public administration. As I scrutinize the nursing curriculum that guides my teaching practices, I am acutely aware of how educators offer students the conceptual tools to rationalize their participation in the ruling relations. Student nurses are not given the analytic tools to recognize the disjunctures in their practices. Rather, they are offered conceptual tools that allow them to leap (conceptually) over that disjuncture to produce *accounts* of that experience that "fit" the philosophy of, what in my faculty, we call the "Caring Curriculum". In their student practica, the disjunctures, that in their classrooms students puzzle over and are taught to conceptualize, do not disappear. At some level, students "know" this. However they (and many of their teachers) lack the analytical tools to make sense of it. I am suggesting that students and teachers alike, need new ways to understand our practices as socially organized and constituted within a complex of social

relations of this contemporary phase of capitalism. Students are told that, as "critical thinkers", they can somehow make autonomous decisions based only in the interests of their patients – as though they were in a "bubble", magically separated from social relations that organize present-day hospital care. Health care, meanwhile, is being incorporated into modes of capital accumulation that make patients into objects, and illness, suffering and its treatment, into issues of productivity, trade and profit. As I noted in Chapter Two, it is only a rare analysis (such as the prolific and important work of Armstrong and Armstrong, et al.) that analyzes nurses' work within these relations of the political economy. Rarer still, is an analysis such as that of Campbell (cited throughout), who goes even further, unpicking the conceptual frame of what is referenced by "political economy" and explicating how the ruling relations of politics and economy enter nurses' lives. Mainly, the nursing discourse, especially the nursing education discourse, treats nursing as if it were completely isolated and open for nurses themselves to control. This does nursing a great disservice.

There is an important project for nurse educators who are persuaded by my analysis. As educators, we can attend more closely to how we might subvert our students' unknowing inculcation into the ruling relations. We can continue the analytic work of understanding how things work, both in nursing education and in nursing practice. We can develop in our students, and in ourselves, an analytical approach that questions whose knowledge we are using. What is the standpoint embedded in that knowledge? As nurses of the academy we are in a position to develop strategies that question the authorized knowledge practices of our time. We can teach in a way that offers students the

theoretical tools through which they can counter "conventional wisdom". We can organize the curriculum in ways that build students' capacity to see and to understand the world from the ground that they inhabit.

I have shown in this dissertation that the practice of nursing is a practice of knowledge and that nurses' knowledgeable practices involve them in troubling relations of state, economy and class power. The renegade nurses of NUC may very well be canaries in the coalmine. They, and others like them, are there, body and soul, experiencing the restructuring that has changed the face of their practice. They are trapped in its suffocating conditions – in it and of it – putting it together as it happens, unwarily contributing to the "institutionalization" of the problems they encounter. My findings presage a future in which, as nurses' consciousness shifts more completely into a restructured "organizational consciousness", nurses will develop increasingly sophisticated ways of "covering over" the disjunctures of their work. Like the nurse manager quoted earlier, nurses will become adept at silencing "the nurse in them" to the authority of managerial knowledge. I worry that this is a generation of nurses who, no longer possessing their own language, and lacking a useful analysis of their social world, will be unable to "speak" the troubles of their work. It is my hope that it is not too late to turn back the tide. That nurses, especially nurse educators, can launch an activist project to open up nurses' gaze to the social relations determining their work. With these empirical tools, I want to believe that the possibility exists for nurses' to organize against the ruling relations of the business paradigm and to "take back" their work, in the interests of patients.

Works Cited

Aiken, L.H., Clarke, S.P., Sloane, D.M., Sochalski, J.A., Busse, R., Clarke, H., Giovannitti, P., Hunt, J., Rafferty, A.M., & Shamian, J. (2002). Hospital nurse staffing and patient mortality, nurse burnout, job dissatisfaction. *JAMA* 288 (16). 1987-1994.

Annis Hammond, Sue. (1998). *The thin book of appreciative inquiry. 2nd ed.* Plano Texas: Thin Book Publishing Co. (www.thinbook.com).

Armstrong, Pat., Amaratunga, Carol., Bernier, Jocelyne., Grant, Karen., Pederson, Ann., & Willson, Kay. (2001) (Eds.), *Exposing privatization: Women and health care reform in Canada.* Aurora Ontario: Garamond Press.

Armstrong, Pat, & Armstrong, Hugh. (1996). *Wasting away: The undermining of Canadian health care.* Toronto: Oxford University Press.

Armstrong, Pat., Armstrong, Hugh., Bourgeault, Ivy., Choiniere, Jacqueline., Mykhalovskiy, Eric, & White, Jerry P. (2000). *"Heal thyself": Managing health care reform.* Aurora Ontario: Garamond Press.

Armstrong, Pat., Armstrong, Hugh., Choiniere, Jacqueline., Mykhalovskiy, Eric, & White, Jerry, P. (1997). *Medical alert: New work organizations in health care.* Toronto: Garamond Press.

Armstrong, Pat., Armstrong, Hugh, & Fegan, Claudia. (1998). *Universal health care: What the United States can learn from the Canadian experience.* New York: W.W. Norton & Co. Inc.

Armstrong, Pat., Chonoiniere, Jacqueline., Feldberg, Gina, & White, Gerry. (1994). *Take care: Warning signals for Canada's health system.* Toronto : Garamond Press.

Bannerji, Himani. (1995). Beyond the ruling category to what actually happens: Notes on James Mill's historiography in "The history of British India". In Marie Campbell, Marie & Ann Manicom. (Eds.). *Knowledge, Experience, and Ruling Relations: Studies in the Social Organization of Knowledge.* (pp. 49-64). Toronto: University of Toronto Press Incorporated.

Bakhtin, M.M. (1981). *The dialogic imagination* (C.E. Emerson & M. Holquist, Trans.). Austin: University of Texas.

Bakhtin, M.M. (1986) *Speech genres and other late essays.* Austin: University of Texas Press.

Barlow, Maude. (2002). *Profit is not the cure: A call to citizens' action to save medicare.* Ottawa: Council of Canadians.

BC Health Management Resource Group (1991)

Bergman, R. (1994). Re-engineering health care. *Hospitals and health networks,* 68 (3), 28-30, 32-34, 36.

Bernier, Jocelyne, & Dallaire, Marlene. (2001). What price have women paid for health care reform? The situation in Quebec. In (Eds.), Pat Armstrong, Carol Amaratunga, Jocelyne Bernier, Karen Grant, Ann Pederson, & Kay Willson. *Exposing privatization: Women and health care reform in Canada.* (pp. 121-161). Aurora Ontario: Garamond Press.

Botting, Ingrid. (2001). Health restructuring and privatization from women's perspective in Newfoundland and Labrador. In (Eds.), Pat Armstrong, Carol Amaratunga, Jocelyne Bernier, Karen Grant, Ann Pederson, & Kay Willson. *Exposing privatization: Women and health care reform in Canada* (pp. 49-89). Aurora Ontario: Garamond Press.

Blomqvist, Ake, & Brown, David. (1994). *Limits to care:Reforming Canada's health care system in an age of restraint* Toronto: CD Howe Institute.

Bourgealt, I.L. & Angus, J. (1999). Pay and human resource management in nursing and medicine: an examination of gendered structural relations between the professions and the state. *Health and Canadian society,* 5(1), 83-110.

Bowker, Marilyn. (2003). *The ABC's of conflict management on the ward.* Nova Clinical Services. Conference booklet: Nursing clinical update May 3, 2003, Victoria. BC.

Brady, Sister Jane Frances. (1998) Quality amid turbulent times. *Nursing administration quarterly,* 22 (4), .20-21.

Brannon, Robert L. (1996). Restructuring hospital nursing: Reversing the trend towards a professional workforce. *International journal of health services,* 26 (4), 643-654.

Burgess, Constance, S.(1998). Managed care: The driving force for case

management. In Elaine Cohen, Elaine & Vivien De Back, Vivien. (Eds.), *The outcomes mandate: Case management in health care today* (pp.). Toronto: Mosby,.

Burke, Ronald J., & Greenglass, Esther R. (2000). Hospital restructuring and downsizing in Canada: Are less experienced nurses at risk? *Psychological reports,* 87, 1013-1021.

Campbell, Marie L. (1984). Information systems and management of hospital nursing: A Study in the social organization of knowledge. Unpublished PhD Thesis. University of Toronto.

Campbell, Marie L. (1988a). Management as ruling: A class phenomenon in nursing. *Studies in political economy,* 27, 29-51.

Campbell, Marie L. (1988b). Accounting for care: A framework for analyzing change in Canadian nursing. *Political issues in nursing: Past, present and future,* 3, 45-69.

Campbell, Marie L. (1990). *Technology and nursing: A review and analysis of selected literature.* Ottawa: Canadian Nurses' Association.

Campbell, Marie L. (1992). Nurses' professionalism in Canada: A labour process analysis. *The international journal of health services,* 22 (4), 751-765.

Campbell, Marie L. (1994). The structure of stress in nurses' work. In (Eds.), B. Singh Bolaria & Harley D. Dickinson, *Health illness and health care in Canada* (2nd ed.). (pp. 592-608). Toronto: Harcourt Brace and Co.

Campbell, Marie L. (1995). Teaching accountability: What counts in nursing education? In Marie Campbell & Ann Manicom, (Eds.), *Knowledge, experience, and ruling relations: Studies in the social organization of knowledge.* (pp. 221-233). Toronto: Toronto University Press.

Campbell, Marie L. (1998a). Institutional ethnography and experience as data. *Qualitative sociology,* 21 (1), 55-73.

Campbell, Marie L. (1998b). *Research on health care experiences of people with disabilities: Exploring the everyday problematic of service delivery.* Paper presented at "Exploring the Restructuring and Transformation of Institutional Processes: Applications of Institutional Ethnography. York University, October 1998.

Campbell, Marie L. (2000). Knowledge, gendered subjectivity, and the

restructuring of health care: The case of the disappearing nurse. In Shiela M. Neysmith (Ed.), *Restructuring Caring Labour: Discourse, State Practice and Everyday Life*. (pp. 187 - 208). Don Mills: Oxford University Press.

Campbell, Marie L., Copeland, Brenda, & Tate, Betty. (1998). Taking the standpoint of people with disabilities in research: Experiences with participation. *Canadian journal of rehabilitation,* 12 (2), 95-104.

Campbell, Marie L., Copeland, Brenda., Tate, Betty, & Project Inter-Seed's Research Team (1999). Project Inter-seed: learning form the health Care experiences of people with disabilities (Final Research Report to the BC Health Research Foundation)

Campbell, Marie L., & Gregor, Frances. (2002). *Mapping social relations: A primer in doing institutional ethnography*. Aurora, Ontario: Garamond Press.

Campbell, Marie L., & Jackson, Nancy S. (1992). Learning to nurse: Plans, accounts, and action. *Qualitative health research,* 2 (4), 475-496.

Campbell, Marie L., & Manicom, Ann. (Eds.) (1995). *Knowledge, experience, and ruling relations: Studies in the social organization of knowledge*. Toronto: University of Toronto Press Incorporated.

Canadian Business (2003). http://search.canadianbusiness.com/search.asp?query=efficiency&start=&total=&stat=new&defaultlanguage=16

Canadian Council on Health Services Accreditation (2003) (History of). http:/www.cchsa.ca/site/pt_link.php?query=History&plain=1

Canadian Council on Health Services Accreditation (2002). *AIM Achieving improved measurement accreditation program.* (Author)

Canadian Council on Health Services Accreditation & Thomas, Jill (1995). *Quality improvement and the client-centred accreditation program prepared by Jill Thomas for the Canadian Council on Health Services Accreditation.* (Author).

Capuano, Terry Ann. (1995). Clinical pathways: practical approaches, positive outcomes. *Nursing management,* 26 (1), 34-37.

Carniol, Ben. (1995). *Case critical: Challenging social services in Canada 3rd ed.* Toronto: Between The Lines.

Carniol, Ben. (2000). *Case critical: Challenging social services in Canada 4th ed.*

Toronto: Between The Lines.

CAW 567 (2003). *Canadian Perspectives*. Summer 2003.

Cawthorne, Jane. (2000). Obscuring a crisis: The obstetricians' and gynecologists' job action and maternal care in Alberta. In Diana Gustafson (Ed.), *Care and consequences: The impact of health care reform.* (pp. 107-126) Halifax Nova Scotia: Fernwood Publishing.

CD Howe Institute (1996-2003). http://www.cdhowe.org/english/publications/currentpubs.html

CIHI (1997). *Bulletin, May 28th 1997: Understanding alternate level of care.* Canadian institute of health information. Distributed by British Columbia acute care facilities and the British Columbia Ministry of Health.

CIHI (2000). *Health care in Canada: A first annual report.* Canadian Institute of Health Information. Ottawa

CIHI (2003) http://secure.cihi.ca/cihiweb/disPage.jsp?cw_page=statistics_results_topic_amcare_e August, 2003.

Clarke, Heather., Spence Laschinger, Heather., Giovannetti, Phyllis., Shamian, Judith., Thomson, Donna, & Tourangeau, Ann. (2001) Nursing shortages: workplace environments are essential to the solution. *Hospital quarterly,* 4 (4), 50-57.

Clow, Barbara. (2001). Health reform, privatization and women in Nova Scotia. In Pat Armstrong, Carol Amaratunga, Jocelyne Bernier, Karen Grant, Ann Pederson, & Kay Willson (Eds.), *Exposing privatization: Women and health care reform in Canada.* (pp. 90-119). Aurora Ontario: Garamond Press.

CNA (1987). *A definition of nursing practice. Standards of nursing practice.* Ottawa: Canadian Nurses Association.

CNA (2002). *Code of ethics for Registered Nurses*. Ottawa: Canadian Nurses Association.

Cohen, Elaine, & De Back, Vivien. (Eds.). (1998). *The outcomes mandate: Case management in health care today*. Toronto: Mosby.

Collaborative Nursing Program of British Columbia. (2002). *Collaborative Curriculum Guide*. Author.

Cybulski, Nancy., Marr, Jo-anne., Milton, Isabel, & Truthwaite, Dalton. (1997). *Reinventing hospitals: On target for the 21st century*. Toronto: McLeod Publishing.

Dechant, Germaine. (1999). Human resource allocation: Staffing and Scheduling. In Judith M. Hibberd, Donna Lynn Smith (Eds.), *Nursing management in Canada* second edition. (pp. 413- 432). Toronto: Saunders.

Devault, Marjorie, & McCoy, Lisa (2002). Institutional ethnography: Using interviews to investigate ruling relations. In Jaber F. Gubrium & James A. Holstein (Eds.), *Handbook of interviewing*. (pp. 751-776). Thousand Oaks: Sage.

deWoody, Suzanne, & Price, Jan. (1994). A systems approach to multidimensional critical paths. *Nursing Management,* 25 (11), 47-51.

Dikenson, Harley D. (1993). Health and health care in Canada. In M. Kanwar & S. Hewa (Eds.), *Issues in Canadian Sociology*. (pp. 249-286). Dubuque, Iowa: Kendall/Hunt.

Dominelli, Lena, & Ankie Hoogvelt. (1996). Globalization, contract government and the Taylorization of intellectual labour in academia. *Studies in Political Economy,* 49 (Spring), 71-100.

du Gay, Paul, & Salaman Graeme. (1992). The cult(ure) of the customer. *The Journal of Management Studies* 29 (5). 615- 634.

Ellis, P.H., & Closson, T. (1994). Realigning around the patient: The application of restructuring and process re-engineering at Sunnybook Health Science Centre. In P. Leatt, C. Lemieux-Charles, & C. Aird (Eds.), *Program Management and Beyond: Management Innovations in Ontario Hospitals*. Ottawa: Canadian College of Health Service Executives.

Esteves, Elizabeth. (2000). Volunteering and market-guided health care reform. In Diana Gustafson (Ed.), *Care and consequences: The impact of health car reform.* (pp. 154-176). Halifax: Fernwood Publishing.

External Nursing Review (1996). (The) Hospital. Confidential document

Finlayson, Mary P., & Gower, Suzanne, E. (2002). Hospital restructuring: identifying the impact on patients and nurses. *Nursing praxis in New Zealand,* 18 (1), 27-35.

Finn, Ed. (1985). *The great deficit hoax.* Ottawa: Canadian Centre for Policy

Alternatives.

Fowlie, Pauline., Francis, Heather, & Russel, Sunny. (2000). A perioperative communication link with families. *Canadian nurse,* 96 (6), 30-33.

Fraser Institute (2003). http://www.fraserinstitute.ca/health/index.asp?snav=he

Fuller, Colleen. (1998). *Caring for profit* . Vancouver : New Star Books Ltd.

Gerteis, Margaret., Edgman-Levitan, Susan., Daley, Jennifer, & Delbanco, Thomas L. (1993). *Through The Patient's Eyes: Understanding and Promoting Patient-Centred Care.* San Francisco: Jossey-Bass

Gervase, Bushe R. (2001). *Clear leadership.* Palo Alto Ca.: Davies-Black Publishing.

Giovannetti, Phyllis., Smith, Donna Lynn, & Broad, Elizabeth. (1999). Structuring and managing health information. In Judith Hibberd and Donna Smith (Eds.), *Nursing management in Canada.* (pp. 297-318). Toronto: Harcourt Brace & Co. Canada Ltd.

Glazer, Nona, Y. (1993). *Women's paid and unpaid labour: The work transfer in health care and retailing.* Philadelphia: Temple University Press.

Grinspun, Doris. (2000). Taking care of the bottom line: shifting paradigms in hospital management. In Diana Gustafson (Ed), *Care and consequences: The impact of health care reform.* (pp. 25-48). Halifax: Fernwood Publishing.

Guilano, K., & Poirier, C. (1991). Nursing Case Management: Critical Pathways to desirable outcomes. *Nursing Management*, 22 (3). 52-57.

Guruge, Sepali., Donner, Gail, J., & Morrison, Lynn. (2000). The impact of Canadian health care reform on recent women immigrants and refugees. In Diana Gustafson (Ed), *Care and consequences: The impact of health care reform.* (pp. 222-242). Halifax: Fernwood Publishing.

Gregor, F., Keddy, B., Foster, S., & Denney, D. (2000). Nova Scotia nurses and health care restructuring: Strategies to manage job displacement. In Diana Gustafson (Ed.). *Care and consequences: The impact of health care reform.* (pp. 72-84). Halifax: Fernwood Publishing.

Griffith, Allison. (1995). *Mothering, schooling and children's development.* Toronto: In Press Incorporated.

Grinspun, Doris. (2000). Taking care of the bottom line: Shifting paradigms in hospital management. In Diana Gustafson (Ed.), *Care and consequences: The impact of health care reform.* (pp. 25-48). Halifax: Fernwood Publishing.

Gustafson, Diana, L. (2000). (Ed.) *Care and consequences: The impact of health care reform.* Halifax: Fernwood Publishing.

Hay, Kathleen., Koegel, Barbara., Teshima, Mary Ellen, & Lewko, Michael. (1998). Geriatric centre of excellence: For a special patient population. *Nursing administration quarterly,* 22 (4), 32-33.

Heap, James L. (1995). Foreword. In Marie Campbell, & Ann Manicom (Eds.), *Knowledge, experience, and ruling relations: studies in the social organization of knowledge* (pp. ix-xv) Toronto: University of Toronto

Hibberd, J. M., & Smith, D.L. (1999). *Nursing Management in Canada 2nd Ed.* Toronto: W.B. Saunders Canada Ltd.

Hudson Institute (2003). http://www.hudson.org/bookstore/index.cfm

Jackson, Nancy. (1995). 'These things just happen': Talk, text, and curriculum reform. In Marie Campbell & Ann Manicom, (Eds.), *Knowledge, experience, and ruling relations: Studies in the social organization of knowledge.* (pp. 164-180). Toronto: University of Toronto Press Incorporated.

Kerr, Christine., Glass, Colin., McCallion, Gillian, & McKillop, Donal. (1999). Best-practice measures of resource utilization for hospitals: a useful complement in performance assessment. *Public administration,* 77 (3), 639-650).

King, C.S. (1995). Question the answers. Managed care: Is it moral? *Advanced practice nursing quarterly,* 1 (3), 7-11.

Kinsman, Gary. (1995). The textual practices of sexual rule: Sexual policing of gay men. In Marie Campbell & Ann Manicom, (Eds.), *Knowledge, experience, and ruling relations: Studies in the social organization of knowledge* (pp. 80-95). Toronto: University of Toronto Press.

Kirby, Michael, J.L. (2002). *The health of Canadians: The federal role. Final Report Volume six: Recommendations for reform.* The standing senate committee on social affairs, science and technology. October 2002.

Krairiksh, M., & Anthony, M. K. (2001). Benefits and outcomes of staff nurses'

participation in decision making. *Journal of nursing administration.* 31 (1), 16-23.

Kruger-Wison, C., & Porter-O'Grady, T. (1999). *Leading the revolution in health care: Advancing systems, igniting performance*. Gaithersburg, Maryland: Aspen Publishers Inc.

Laschinger, H.S., Shamian, J., & Thomson, D. (2001). Impact of magnet hospital characteristics on nurses' perceptions of trust, burnout, quality of care and work satisfaction. *Nursing Economics,* 19 (5), 209-219.

Laxer, James. (1996). *In search of a new left: Canadian politics after the neoconservative assault.* Toronto: Viking.

Leduc Browne, Paul. (2000). *Unsafe practices: Restructuring and privatization in Ontario health care*. Ottawa: Canadian Centre for Policy Alternatives.

Lichtig, L.K., Knauf, R.S., & Millholland, D.K. (1999). Some impacts of nursing cuts on acute care hospital outcomes. *Journal of nursing administration,* 29 (2), 25-33.

Lomas, Jonathan, Woods, John, & Veenstra, Gerry. (1997). Devolving authority for health care in Canada's provinces: 1. An introduction to the issues. *Canadian Medical Association Journal* 156 (3). 371- 377.

Macleans Magazine. (1999, June 7th). *The first ranking health report,* 112 (23), 112-123.

Macleans Magazine. (2000, June 5th). *The best health care: The second annual Mcleans ranking,* 113 (23), 18-33.

Macleans Magazine. (2003, June 16th) *The fifth annual health-care ranking*, 116 (24), 22-30.

Marx, Karl, and Engels, Frederick. (1970). *The Germen ideology, part 1*. New York: International Publishers.

MCAP™ Oakgroup (1999). *MCAP™ criteria manual 2nd ed.* Author.

McCallion, Gillian., McKillop, Donal., Glass, Colin, & Kerr, Christine. (1999). Rationalizing Northern Ireland hospital services towards larger providers: Best-practice efficiency studies and current policy. *Public money and management,* 19 (2), 27-32.

McCormick, Janice (1997). *The discourses of control: Power in nursing.* Unpublished doctoral dissertation, University of British Columbia, Vancouver, BC.

McCoy, Lisa. (1995). Activating the photographic text. In Marie Campbell &

Ann Manicom, (Eds.), *Knowledge, experience, and ruling relations: Studies in the social organization of knowledge* (pp. 181-192).

McCoy, Lisa. (1999). *Accounting discourse and textual practices of ruling: A study of institutional transformation and restructuring in higher education.* Unpublished PhD dissertation. Department of Sociology and Equity Studies in Education, Ontario Institute for studies in education of the University of Toronto. Toronto.

McFarlane, Lawrie, & Prado, Carlos. (2002). *The best-laid plans: Health care's problems and prospects*. Montreal and Kingston: McGill-Queen's University Press.

McKillop, Ian., Pink, George, & Johnson, Lina, M. (2001). *The financial management of acute care in Canada: A review of funding, performance monitoring and reporting practices*. Ottawa: Canadian Institute for Health Information.

McQuaig, Linda. (1995). *Shooting the hippo: Death by deficit and other Canadian myths*. Toronto: Penguin Books Canada Ltd.

Mead, George, Herbert. (1964). *On social psychology: Selected papers*. A. Strauss (Ed.), Chicago: University of Chicago Press.

Messner, Roberta, L. & Lewis, Susan, J. (1996). *Increasing patient satisfaction: A guide for nurses.* New York: Springer Publishing Co.

Miller, M. A. (1997). Effects of the program-management model: a case study on professional rehabilitation nursing. *Nursing administration quarterly* 21 (2). 47-54.

Mueller, Adele. (1995). Beginning in the standpoint of women: An investigation of the gap between 'Cholas' and 'Women of Peru'. In Marie Campbell & Ann Manicom (Eds.), *Knowledge, experience, and ruling relations: Studies in the social organization of knowledge* (pp. 96-107). Toronto: University of Toronto Press Incorporated.

Mykhaloviskiy, Erik. (2001). Troubled hearts, care pathways and hospital restructuring: Exploring health services research as active knowledge. In (Eds.) Dorothy E. Smith & Stephen Dobson. S*tudies in institutional ethnography in studies in cultures, organizations and societies* (*Special issue),* 7 (2), 269-296.

Ng, Roxana. (1995). Multiculturalism as ideology: A textual analysis. In Marie Campbell & Ann Manicom (Eds.). *Knowledge, experience, and ruling relations: Studies in the social organization of knowledge* (pp. 35- 48). Toronto: University of Toronto Press Incorporated.

NRGH (1998). Integrated health programs. Confidential Document

Norrish, B.R. & Rundall, Thomas G. (2001). Hospital restructuring and the work of registered nurses *The Millbank quarterly, 79 (1),* 55-79.

O'Brian, Barbara L. (1998). Nursing organizational structure. *Nursing administration quarterly,* 22 (4), 21-23.

Osberg Lars, & Fortin, Pierre. (1996). *Unnecessary debts.* Toronto: James Lorimer and Co.

Pence, Ellen. (2001). Safety for battered women in a textually mediated legal system. In (Eds.) Dorothy E. Smith & Stephen Dobson. S*tudies in institutional ethnography in studies in cultures, organizations and societies (Special issue)*, 7 (2), 199-229.

Perley, Mary Jo, & Raab, Abe. (1994). Beyond shared governance: Restructuring care delivery for self-managed work teams. *Nursing administration quarterly,* 19 (1), 12-20.

Peterson, Frederick L., Cooper, Roger, & Scherer, Robert. (2000). Organizational change: Initial results in a health care setting. *Psychological reports,* (86), 608-610.

Porter, Theodore. (1995). *Trust in numbers: In pursuit of objectivity in science and public life.* Princeton: Princeton University Press.

Potter, Patricia Ann, & Perry Griffin. (1997). *Canadian fundamentals of nursing.* Janet Ross Kerr & Mary Kosco Sirotnik (Canadian Eds.), Toronto: Mosby Year Book.

Powell, Francis D., & Wesson, Albert, F. (1999). (Eds.). *Health care systems in transition: An international perspective.* Thousand Oaks: Sage Publications.

Purkis, Mary Ellen. (1997). The "social determinants" of practice? A critical analysis of the discourse of health promotion *Canadian journal of nursing research,* 29 (1), 47-62.

Purkis, Mary Ellen, (1999). Embracing technology: an exploration of the effects of writing nursing. *Nursing inquiry,* 6, 147-156.

Purkis, Mary Ellen. (1999). *A question of participation: on using a participatory approach in health care research.* Paper submitted to the Qualitative Analysis Conference May 14th-16th, 1999. Fredericton, New Brunswick.

Purkis, Mary Ellen. (2001). Managing home nursing care: Visibility,

accountability and exclusion. *Nursing inquiry,* 8 (3), 141-150.

Rankin, Janet, M. (2001). Texts in action: How nurses are doing the fiscal work of health care reform In (Eds.) Dorothy E. Smith & Stephen Dobson. S*tudies in institutional ethnography in studies in cultures, organizations and societies (Special issue)*, 7 (2), 251-268.

Rankin, Janet, M. (2003). Patient satisfaction: Knowledge for ruling hospital reform – An institutional ethnography *Nursing inquiry,* 10 (1), 57-65.

Regional hospital (1997). *Financial management and operational assessment: Review team report.* Confidential document.

Richardson, Trudy. (1994) *Patient focused care* Edmonton: United Nurses of Alberta.

Ritter-Teitel, Joanne. (2002). The impact of restructuring on professional nursing practice. *JONA,* 32 (1), 31-41.

RNABC (Registered Nurses Association of BC) (1996a). *Patient care delivery systems: Implications for nursing practice.* Vancouver, Author.

RNABC (Registered Nurses Association of BC). (1996b). *Patient care delivery systems: An evaluation framework.* Vancouver: Author.

Robbins, Stephen, P. (1984). *Management: Concepts and practices.* New Jersey: Prentice Hall Inc.

Robbins, Stephen, P. (1990). *Management: Concepts and practices 2nd Edition* Scarborough : Prentice Hall Canada Inc.

Robbins, Stephen, P., & Langton, Nancy. (1999). *Organizational behaviour: concepts, controversies and applications.* Scarborough: Prentice Hall Canada Inc.

Rocchiccioli, Judith, T. & Tilbury, Mary, S. (1998). *Clinical leadership in nursing.* Philadelphia: W.B. Saunders.

Roggenkamp, Susan, D., and White, Kenneth R. (2001). Is hospital case management a rationalized myth? *Social science and medicine* 53. 1057-1066.

Romanow, Roy (2002). *Building on values: The future of health care in Canada: Final report Commission on the Future of Health Care in Canada.* Saskatoon: The Commission.

Rose, N. (1991). Governing by numbers: Figuring out democracy. *Accounting,*

organizations and society, 16 (7), 673-692.

Rosenman, R.K., Siddharthan, K. & Ahern, M. (1997). Output efficiency of health maintainance organizations in Florida. *Health economics* 6. 295-302.

Sandhu, Balbir, K., Duquette, Andre, & Kérouac Suzanne. (1992). How assignment patterns drive our professional practice. *Canadian journal of nursing administration,* 5 (3), 9-14.

Shamian, J., Kerr, M.S., Laschinger, H.K.S., & Thomson, D. (2002). A hospital level analysis of the work environment and workforce health indicators for registered nurses in Ontario's acute-care hospitals. *Canadian journal of nursing research,* 33 (4), 35-50.

Shears, Ann Marie, Wyenn, Gwen, & Kutzleb, Judy. (1998). Survival depends on redesigning patient care delivery. *Nursing Administration Quarterly,* 22 (4), 23-26.

Short, Ronald R. (1998). *Learning in relationship.* San Fransisco: Learning in Action Technologies. (www.learninginaction.com).

Simpson, Patricia, E., and Porte, Sheila. (2000). "And then there were none": An experience in building an integrated health service among the Chippewas of Georgina Island. In Diana Gustafson (Ed). *Care and consequences: The impact of health care reform.* (pp. 199-221). Halifax: Fernwood Publishing.

Skelton Green, Judith. (1999). Managing change. In Judith M. Hibberd, & Donna Lynn Smith (Eds.), *Nursing management in Canada second edition.* (pp. 455-470) Toronto: W.B. Saunders Canada.

Smith, Donna Lynn., Armann-Hutton, Donna., Inions, Noela, & Hutton, Dennis. (1999). Accountability, standards and quality. In Judith M. Hibberd, & Donna Lynn Smith (Eds.), *Nursing management in Canada 2nd ed.* (pp.369-392). Toronto: W.B. Saunders Canada.

Smith, Dorothy E. (1987). *The everyday world as problematic: A feminist sociology.* Toronto: University of Toronto Press.

Smith, Dorothy E. (1990a). *The Conceptual practices of power: A feminist sociology of knowledge.* Toronto: University of Toronto Press.

Smith, Dorothy E. (1990b). *Texts, facts, and femininity: Exploring the relations of ruling.* New York: Routlidge.

Smith, Dorothy E. (1999). *Writing the social: Critique, theory, investigations.* Toronto: University of Toronto Press.

Smith, Dorothy (2001). Texts and the ontology of organizations and institutions. *Studies in cultures organizations and societies.* 7 (2) 159- 198.

Smith, Dorothy, & Dobson, Stephan. (2001) (Eds.). Special issue: Studies in institutional ethnography. *Studies in cultures organizations and societies.* 7 (2).

Smith, George. (1995). Accessing treatments: Managing the AIDS epidemic in Ontario. In Marie Campbell & Ann Manicom (Eds.), *Knowledge, experience, and ruling relations: Studies in the social organization of knowledge*. (pp. 18-34). Toronto: University of Toronto Press Incorporated.

Smith, George B., Danforth, Debra A., & Owens, Phyllis J. (1994). Role restructuring: Nurse, case manager and educator. *Nursing administration quarterly,* 19 (1), 21-32.

Spitzer, D. (2000). "They don't listen to your body": Minority women, nurses and childbirth under health reform. In Diana Gustafson (Ed). *Care and consequences: The impact of health reform.* (pp. 85-106). Halifax: Fernwood Publishing.

Street, Annette, F. (1992). *Inside nursing: A critical ethnography of nursing practice.* New York: State University of New York Press.

Street, Annette, F. (1995). *Nursing replay: Researching nursing culture together.* Melbourne: Churchill Livingstone.

Street, Annette, F. (1998). Competing discourses in palliative care. In Judith Parker & Sanchia Aranda (Eds.), *Palliative care: explorations and challenges*. (pp. 69–81*)*. Philadelphia: MacLennan & Petty.

Teeple, Gary. (2000). *Globalization and the decline of social reform: Into the twenty-first century*. Aurora: Garamond Press.

(The) Hospital(1996). *In Pursuit of quality: An assessment of the quality of care and quality of worklife at (The) Hospital: Summary Report.* Confidential document

Thomas, Paul G. (1996). Beyond the buzzwords: Coping with change in the public sector. *International review of administrative sciences,* 62, 5-29.

Tomlinson, J. (1981). The economics of politics and public expenditure: A critique. *Economy and society,* 10 (4), 381–402.

Toronto Star. (February 4th 1999) *Report cards proposed for health-care services.* A6.

Townley, Barbara. (1996). Accounting in detail: Accounting for individual performance. *Critical perspectives on accounting,* 7, 565-584.

Transken, S. (2000). Dissolving, dividing and distressing: Examining cutbacks to programs responding to sexual violation. In Diana Gustafson (Ed), *Care and consequences: The impact of health care reform.* (pp. 127-153). Halifax: Fernwood Publishing.

Tri-Council Policy Statement (1998). *Ethical conduct for research involving humans.* Medical Research Council of Canada; Natural sciences and Engineering Research Council of Canada; Social Sciences and Humanities Research Council of Canada.

Tupper, Allan. (2001). The contested terrain of Canadian public administration in Canada's third century. *Journal of Canadian studies* 35 (4). 142-160

Ueda, Yoko. (1995). Corporate wives: Gendered education of their children. In Marie Campbell & Ann Manicom, (Eds.), *Knowledge, experience, and ruling relations: Studies in the social organization of knowledge* (pp. 122-134). Toronto: Toronto University Press.

VanDeVelde-Coke, Susan. (1999). Restructuring health agencies: From hierarchies to programs. In J.M. Hibberd, D.L. Smith (Eds.), *Nursing management in Canada 2nd Edition.* (pp. 135-156). Toronto: W.B. Saunders Canada Ltd.

Varcoe, Colleen & Rodney, Patricia. (2002). Constrained agency: The social structure of nurses' work. In B.S. Bolaria & H. Dickenson (Eds.), *Health, illness and health care in Canada 3rd edition.*(pp. 102-128). Toronto: Harcourt Brace.

Varcoe, Colleen., Rodney, Patricia., & McCormick, Janice. (2003 in press). Health care relationships in context: An analysis of three ethnographies. *Qualitative health research.*

Vološinov, V.I. (1973). *Marxism and the philosophy of language.* (I.R. Titunik, Trans.), New York: Academic Press

Weisinger, Hendrie. (1998). *Emotional intelligence at work.* San Francisco: Jossey-Bass.

Weston, Wayne W. (2001). Informed and shared decision making: The crux of patient centred care. *Canadian Medical Association Journal,* 165 (4), 438-439

Windle, Pamela E. (1994). Critical pathways: An integrated documentation tool. *Nursing management,* 25 (9), 80F-80P.

Workman,Thom, W. (1996). *Banking on deception: The discourse of fiscal crisis* Halifax: Fernwood Publishing.

Wright, Lorraine & Leahy, Maureen. (1999). Maximizing time, minimizing suffering: The 15-minute (or less) family interview. *Journal of family nursing,* 5 (3), 259-275.

Appendix A Consent

Consent for participation in formal research interviews

You are being invited to participate in a study entitled **How nurses practice health care reform in hospitals: an institutional ethnography** that is being conducted by JANET RANKIN. Janet Rankin is a graduate student in the department of Human and Social Development at the University of Victoria.

Contacts:
You may contact Janet Rankin at 250-751-8649 or rankin@island.net .

As a graduate student, this research is part of the requirements for a PhD degree in the Faculty of Human and Social Development and it is being conducted under the supervision of Dr Marie Campbell. You may contact Marie Campbell at 250-721-8203 or mcampbell@hsd.uvic.ca

Purpose of the research:
The purpose of the research is to discover what actually happens within the nurses' work processes that contribute to accomplishing the goals of health care reform. In essence, the research question asks: How do organizational strategies of health care reform get enacted in the work processes of nurses? Health care reform has motivated specific organizational efforts/technologies for expediting the treatment of patients and "doing more with less" or "working smarter". Information technologies are an increasingly important component of this work environment. While new uses of information are built into reformed organizational/managerial practices, there has been no new design for how nurses' practical "hands on" work with patients is to be "reformed". Nurses learn to cope with "information-based organizational technologies" themselves. My interest is to discover how nurses innovate, make do, and adapt to the new work environment. This interest, examined through an institutional ethnography leads me to explore both the changing environments structured by the new information technologies **and** what nurses do as everyday/everynight practices that make the new systems work..

Potential benefits of the research:
Institutional ethnography is a way to critically examine the social organization of contemporary nursing. In particular it examines how "texts" influence and organize nursing practice. Nurses and other people whose work supports or influences nurses' work are knowledgeable experts in their work processes. Even clients are knowledgeable about their own work as clients. Commonly though, the larger organizational processes influencing health care work are not visible from within it. The research attempts to unravel some of the taken for granted activities that construct contemporary nursing and that, understood through this analytic lens, may offer useful insight for nursing education, policy and practice.

In this study work is defined generously as all the material effort, and all the activities people engage in that sustains the organization of hospitals.

Participants:
Informants are recruited informally, generally by word of mouth, using a snowball technique. One person in the hospital refers me on to another person in the hospital who "knows about" or who "knows *more* about" work processes related to the how patients enter, move through, move around in, and move out of the hospital system.

People may "self refer" into the study when, during the course of everyday interactions, I talk about my research interests. Many people have stories to tell about their experiences with Canadian health care and are eager to share these stories for the purposes of research. Several administrators and colleagues in various other BC hospitals have expressed interest in discussing their work processes and relations with boards, ministries, professional regulatory bodies etc.

What to expect in the interview:
In this research, "interviewing" is better described as "talking to people". Opportunities to talk to people about institutional processes occur in a variety of formal and informal settings. Conversations with informants are not standardized, the point of each interaction is to discover the work practices of everyday life, to learn about what each informant actually does, the effort expended that "holds" the organizational structure together. Questions will focus on your work related to "finding beds" or about your work related to the course of a hospitalization. **Formal interviews by appointment:** If you agree to voluntarily participate in this research, your participation will include an audiotaped conversation that will be approximately one hour at a time and place mutually convenient.
Informal talks arising out of participant observations: If you agree to voluntarily participate in this research, information you give me about your work processes will be anonymously noted in field notes.

Risks:
There are no known or anticipated risks to you related to your participation in the research.

Anonymity and Confidentiality:
In terms of protecting your anonymity, in all research writing, references to individuals or the naming of particular hospitals will be anonymous (through the use of pseudonyms). Stories or accounts of particular experiences will not be recognizable to anyone except perhaps informants. "Stories" are merely an entry point into the wider organizational structures. Analytically relevant stories might be "familiar" to anyone who works in the health care setting, however contextual details are changed or omitted to provide individual or agency anonymity.

Participation by people variously located around British Columbia, assists to protect the anonymity of all research participants. The research writings will acknowledge that data was drawn from a variety of sites. References will be made to "a staff nurse in a BC hospital" or "a patient services manager" etc.

Formal interviews will be audio taped. Afterwards the taped conversation will be transcribed into note form. All identifying information (such as names used during the interview, or other identifiable references) will be omitted from the transcripts. The tapes will be kept in a secure location and will be available only to the researcher.

Participation in the study will be kept private and confidential. Names will not be used in any of the research documentation. The tapes will be kept in a secure place, separate from the interview transcripts and the consent forms.

All interview tapes will be erased once the project has been completed. Transcripts of the interviews will be shredded.

Voluntary participation:
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 your data will not be cited in the research findings. The tape and the transcript of the conversation will be destroyed if you choose to withdraw.

Research findings:
It is anticipated that the results of this study will be shared with others through published articles, presentations at conferences and at nurses' professional meetings. Presentations of the research findings will be publicized via posters, newsletters, and formal invitation. The approved dissertation will be made available through the library at the University of Victoria."

In addition to being able to contact the researcher (Janet Rankin) and the supervisor (Dr. Marie Campbell) 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 researcher.

_____ _____

Participant Signature Date

A copy of this consent will be left with you and a copy will be taken by the researcher.

Appendix B Inpatient Location Statistics

RUN DATE: 23/06/00 — Regional Hospital — PAGE 1
RUN TIME: 0723 — PERIOD INPATIENT LOCATION STATISTICS

FOR: 0003

LOCATION		BD DAYS	PERIOD TO DATE ADM	DIS	EXP	PD	LD	AV LOS	AV CEN	% OCC	YEAR TO DATE ADM	DIS	EXP	PD	LD	AV LOS
NR	FLOOR	840	96	131	2	806	867	4.9	28.9	96.19	157	396	9	2386	2680	4.5
NR 1	1 SAME DAY ADMIT	0	0	0	0	0	0	0.0	0.0	N/A	5	0	0	0	5	1.0
NR	FLOOR	476	20	61	7	473	495	5.3	16.0	99.37	65	178	19	1392	1519	6.2
NR	FLOOR	1050	20	102	20	1010	1082	9.2	36.1	100.20	77	297	56	2967	2810	3.9
NR	FLOOR - OVERFLOW	0	0	0	0	0	0	0.0	0.0	N/A	0	0	0	0	0	0.0
NR CANCEL	CANCEL ADMISSIONS	0	0	0	0	0	14	1.0	0.0	N/A	1	1	0	6	12	1.6
NR ICU	INTENSIVE CARE	336	18	18	4	234	364	4.2	6.9	71.13	62	51	15	801	1117	5.1
NR REH	REHABILITATION UNI	588	6	34	0	567	625	17.4	20.1	95.75	11	93	1	1806	1967	10.1
NR SDCU	SURGICAL DAY CARE	0	0	0	0	0	0	0.0	0.0	N/A	1	0	0	27	28	1.1
SUBTOTALS		3248	118	346	38	3090	3387	6.6	110.5	95.23	382	1022	100	9385	9986	6.5
NR	FLOOR	896	30	140	2	866	941	5.4	30.9	96.69	112	455	7	2930	3019	4.5
NR .	FLOOR OVERFLOW	0	0	0	0	0	0	0.0	0.0	N/A	0	0	0	0	0	0.0
NR 3SDA	3 SAME DAY ADMIT	0	68	0	0	0	69	1.0	0.0	N/A	218	0	0	1	219	1.0
NR	FLOOR	980	55	164	4	861	904	4.2	30.4	86.84	143	444	10	2524	2584	4.5
NR	FLOOR - OVERFLOW	0	0	0	0	0	0	0.0	0.0	N/A	0	0	0	0	0	0.0
NR 6SDA	SAME DAY ADMIT	0	50	0	0	0	63	1.0	0.0	N/A	220	0	0	0	223	1.0
SUBTOTALS		1876	213	304	5	1717	1967	3.7	61.3	91.52	693	899	17	5055	5550	3.5
NR COMP	COMPANION BABE	0	1	1	0	3	3	3.0	0.1	N/A	2	3	0	11	11	3.7
SUBTOTALS		0	1	1	0	3	3	3.0	0.1	N/A	2	3	0	11	11	3.7
NR EMOD	EMERGENCY OVERFLOW	0	445	91	8	316	567	1.2	11.3	N/A	1216	245	23	849	1594	1.2
SUBTOTALS		0	445	91	8	316	567	1.2	11.3	N/A	1216	245	23	849	1594	1.2
NR PEDS	PEDIATRICS	336	69	69	0	207	218	2.3	7.4	61.61	233	290	1	717	745	2.4
NR PEDSSDA	PEDIATRICS SAME DA	0	11	0	0	0	11	1.0	0.0	N/A	20	0	0	0	20	1.0
SUBTOTALS		336	80	69	0	207	229	2.2	7.4	61.61	253	290	1	717	765	2.3
NR	2 SAME DAY ADMIT	0	4	0	0	0	4	1.0	0.0	N/A	12	0	0	0	12	1.0
NR	FLOOR	476	5	88	0	293	273	2.7	10.5	61.55	22	267	0	816	826	2.8
NR	FLOOR - OVERF	0	0	0	0	0	0	0.0	0.0	N/A	0	0	0	0	0	0.0
NR LR	LABOUR ROOM	0	77	2	0	28	83	1.0	1.0	N/A	222	13	0	83	242	1.0
SUBTOTALS		476	86	90	0	321	360	2.9	11.5	67.44	256	280	0	899	1080	2.0
NR NURSY	NURSERY	560	45	12	0	141	170	2.4	5.0	25.18	110	36	0	441	499	4.0

Appendix C ALC Designation Form

DEFINITION OF ALTERNATE LEVEL OF CARE (ALC):
An Alternate Level of Care patient is a patient who has finished the acute care phase of his/her treatment.

(The following information is required to assist with Discharge Planning and for the purposes of data collection)

☐ **ALC: On Admission** Reason:_____

☐ **ALC: Waiting Placement** - type of placement requested:

Extended Care ☐ Intermediate Care ☐ Rehab. Facility ☐

☐ **ALC: Other** _____

☐ **Discharge Plan in Place** **Y** ☐ **N** ☐

☐ **Barriers to discharge:**

COMMUNITY	HOSPITAL	PATIENT/FAMILY
☐ Waiting LTC Assessment ☐ Long Term Care Bed Unavailable ☐ Home Nursing Unavailable ☐ Waiting Home Care Assessment ☐ Home Support Unavailable ☐ Other _____	☐ Waiting Test/Proc specify ☐ Delay Test Results Lab ☐ X-ray☐ ☐ Other _____ _____	☐ Refuse LTC ☐ Respite ☐ Family caregiver Unavailable ☐ Other _____ _____

(A patient is classified as ALC when the patient's physician indicates that the patient no longer requires acute care)

☐ **ALC: Designation Date:** _____
Day Month Year

_____
Physician Signature

ALTERNATE LEVEL OF CARE (ALC) DESIGNATION FORM
750-60-Rev. 2/96

INSTITUTION:

Fiscal Year: 1997 APR01 JUN26 97

Patient Service 1	Description 2	Plx Level 3	Typical Cases 4	Typical Weighted Cases 5	% Typical Weighted Cases 6	Atypical Cases 7	Atypical Weighted Cases 8	Total Cases 9	Total Weighted Cases 10	% Hc Weighte 11
99	ALTERNATE LEVEL OF CARE									
		1	1	0.7	4.0	5	17.6	6	18.4	
		2	0	0.0	0.0		0.7	1	0.7	
		9	1	0.3	100.0	0	0.0	1	0.3	
	Total:		2	1.0	6.1	6	18.3	8	19.3	
	Institution Totals:		1234	1283.6	70.8	319	528.9	1553	1812.3	10

Appendix E Sample Page of Patient Satisfaction Survey

98. Did the hospital staff assist you to get this help before you left the hospital?
    1. Yes 2. No

99. How much time did a health professional spend with you discussing what you should do at home after you were discharged?
    1. Not Enough Time
    2. Enough Time
    3. Too Much Time
    4. Don't Know

THINKING ABOUT YOUR OVERALL HOSPITAL STAY

How would you rate the following?

100. The courtesy and helpfulness of your doctors:
    1. Excellent
    2. Very Good
    3. Good
    4. Fair
    5. Poor

101. The courtesy and helpfulness of your nurses:
    1. Excellent
    2. Very Good
    3. Good
    4. Fair
    5. Poor

102. The availability of nurses:
    1. Excellent
    2. Very Good
    3. Good
    4. Fair
    5. Poor

103. The courtesy and helpfulness of the hospital staff:
    1. Excellent
    2. Very Good
    3. Good
    4. Fair
    5. Poor

104. The cleanliness and comfort of your room:
    1. Excellent
    2. Very Good
    3. Good
    4. Fair
    5. Poor

105. The quality of the food:
    1. Excellent
    2. Very Good
    3. Good
    4. Fair
    5. Poor

106. The overall care you received at the hospital?
    1. Excellent
    2. Very Good
    3. Good
    4. Fair
    5. Poor

107. Would you recommend this hospital to your friends and family?
    1. Yes 2. No

108. If you had to enter the hospital again, would you prefer to return to the same hospital or go to a different hospital?
    1. Prefer Same Hospital
    2. Prefer Different Hospital

109. What is the most important reason you would come back to this hospital?
    1. My Doctor
    2. Location Convenient
    3. Good Quality of Medical Care
    4. Good Quality of Nursing Care
    5. Good Reputation of Hospital
    6. Cleanliness of Facilities
    7. Liked the Staff
    8. Other (specify) Specialty services available
    9. Don't Know/Not Sure

110. How much do you think you were actually helped by your hospital stay?
    1. A great deal
    2. Somewhat
    3. Not too much
    4. Not at all

111. Did the way you were treated in hospital help you get better, make you worse or slow down your recovery?
    1. Helped me get better faster
    2. Made my health worse
    3. Slowed down my recovery

Appendix F Nurses' Worksheet With ALC "Diagnosis"

WORKSHEET

ROOM	NAME	DIAGNOSIS	PHYSICIAN	
301-1 PP DNR-2	85	ALC		
301-2 DNR-3	78	CAD Hernia		
303-1 DNR-5	87	CHF MI		
303-2	62	ⓛ HEMIPARESIS ⓡ TEMPORAL GLIOMA		
303-3	75	CA ESOPH. & Fistula		
303-4 DNR-3	80	ALC CARDIAC MYOPATHY		
304 pos. fam DNR-2	80	Ca prostate & Brain mets		
305 DNR-3	90	C-DIFF		
306		& Met. BREAST CA		
307 PP DNR-3	70	CVA	(F)	
308-1	73	ALC		
308-2 DNR-3	90	Sepsis ? MI ? CVA		
308-3 DNR-3	75	PAIN (R) HIP POST FALL	(F)	
308-4				
309-1		#L hip	(F)	

Appendix G

Clinical Pathway for Hip Arthroplasty

PRE-OPERATIVE ASSESSMENT/
EDUCATION AND DISCHARGE PLANNING

SUMMARY FROM PRE-ADMISSION CLINIC COMPLETE: ☐ YES ☐ NO

TOTAL HIP REPLACEMENT CARE PATHWAY

O.R. DAY - POST OP DATE:_____	DAY 1 DATE: _____	DAY 2 DATE: _____	DAY 3 DATE: _____	DAY 4 DATE: _____	DAY 5 DATE: _____
1. TEACHING/DISCHARGE PLANNING: - D B & C - Foot and ankle exercises - Turn with an abductor pillow/other - PCA/pain control	- D B & C - Reinforce hip precautions - Review pain control → transition to oral analgesic - Bed exercises - Activity progress	- Reinforce hip precautions - Bed exercises - Transfers bed ↔ stand ↔ sit - Gait training with walker	- Gait training walker ↔ crutches - Referrals eg Social Services, Rehab - Continuing Care referral prn	- Stair ambulation	- Review precautions; equipment, home exercises - Referrals arranged
2. ACTIVITY: - Turn q2-3h in bed with assist, Abductor pillow in situ - D B & C - Foot and ankle exercises	- Turn q2-3h in bed with Abductor pillow - Bed exercises - Stand with walker	- Turn q2-3h in bed - Sit out of bed ½ → 1 h - Supervised transfers - Physio BID /Bed exercises/ Ambulate with walker	- Turn q2-3h in bed - Sit out of bed - Independent transfers - Physio BID /Bed exercises/ Ambulate with walker → crutches	- Turn q2-3h while in bed - Independent ambulation walker & crutches - Physio BID /Exercise and/or ortho class - Practice stairs	- Final review with O.T. - Physio final review exercises and gait - Meet at vehicle to check transfer method
3. ADL's: - Independent as able - Major assist with bath and diet	- Major assist with bath and diet	- Partial assist with bath and diet	- Partial assist with bath - General - Review Hip Precautions with aids with O.T.	- Dressing techniques reviewed - Review car transfer - Review bath aids - Check home management - Show 'THR' video	
4. DIET: - Sips → clear fluids	- Clear fluids → general	- General - Fruit tax daily - Encourage fluids	- General	- General	- General
5. MEDICATIONS/IV THERAPY: - Maintain IV - PCA - I.M. pain med - Indocid Suppository - Anti-emetic - IV antibiotics X 24 h - Transfuse blood as per orders - Anticoagulent therapy	- Cap IV if Hgb > 90 - D/C antibiotics - Begin oral analgesic overlap with PCA - Daily coumadin administration - Personal meds - Indocid Suppository	- D/C IV - D/C PCA; oral analgesic - Coumadin administration - Personal meds - Oral iron supplement if marginal Hgb - Laxative of choice e.g. Colace, Doxidan, Magnolax	- Oral analgesic - Coumadin - Personal meds - Oral iron supplement	- Oral analgesic - Coumadin - Personal meds - Iron supplement	- Oral analgesic - Coumadin - Personal meds - Iron supplement
6. ASSESSMENT/ TREATMENT: - Post-op head → toe - Neurosensory check q1h X 2; if stable q4h - V.S. q1h X 2; q4h - Monitor and empty drain q4h - Fluid balance - O_2 per nasal prongs - Monitor urine output and empty q12h - Pain scale - Check dressing, reinforce X 1 - Place bed in Trendelenburg position	- Neurosensory checks q4h - V.S. q4h - D/C drain - Fluid balance - Monitor urine output and empty q12h - Check dressing; operative leg - Check dressing; operative leg edema; assess DVT - Skin integrity assess q shift with bath or turns - Chest and abdomen assessment - Trendelenberg bed when patient at rest	- Neurosensory check q12h - V.S. q1 d. - Fluid balance - D/C Foley - Monitor voiding - Chest assessment - Change dressing; reduce to mepore - Operative leg edema; assess DVT q shift - Skin integrity assess q shift - Bowel assessment - Trendelenburg bed	- Neurosensory check q shift - V.S. q1 d. - Assess wound; dressing and change prn - Operative leg edema; assess DVT - Skin integrity; voiding; B.M. - D/S; G/S suppl if no B.M. - Trendelenburg bed	- Neurosensory check q shift - V.S. O.D. prn - Assess wound; dressing and change prn - Operative leg edema; assess DVT - Skin integrity; voiding and B.M. assessment q shift - Fleet enema as needed - Trendelenburg bed	- Neurosensory check q shift - V.S. O.D. pm - Operative leg edema; assess DVT - Skin integrity q shift - B.M. assessment O.D. - Trendelenburg bed - Leave clean, dry incisions open to air
7. TESTS:	- Hgb - INR	- INR - Urine R & M, C & S	- INR	- INR	- INR

Appendix H Patient Responsibility Form

PATIENT RESPONSIBILITY IN PREPARING FOR SURGERY

Preparation for surgery begins long before you arrive at the hospital. You and your family as important team members can help ensure a smooth recovery and discharge from the hospital. The following are minimum requirements for you to arrange prior to your surgery date. ***Your surgery will be delayed and rescheduled if these arrangements have not been made.***

Please complete the following form and return it to the Nurse at your next appointment in the Pre-Admission Clinic.

1. ☐ I AGREE that discharge is planned for the 5th day following surgery.
2. ☐ I AGREE to a discharge time by 11:00 A.M.
3. ☐ I HAVE made arrangements for a responsible adult with an appropriate vehicle to transport me home.
4. ☐ I HAVE acquired the following equipment (*as appropriate*):

☐	Walker	☐	Crutches
☐	Raised Toilet Seat	☐	Reacher
☐	Long Handled Shoe Horn	☐	Sock Aide
☐	High Chair	☐	Raised Bed
☐	Commode		

(refer to your patient information pamphlet for phone numbers and resources)

5. ☐ I HAVE started my pre-admission exercises.
6. ☐ I HAVE arranged for help at home following discharge.

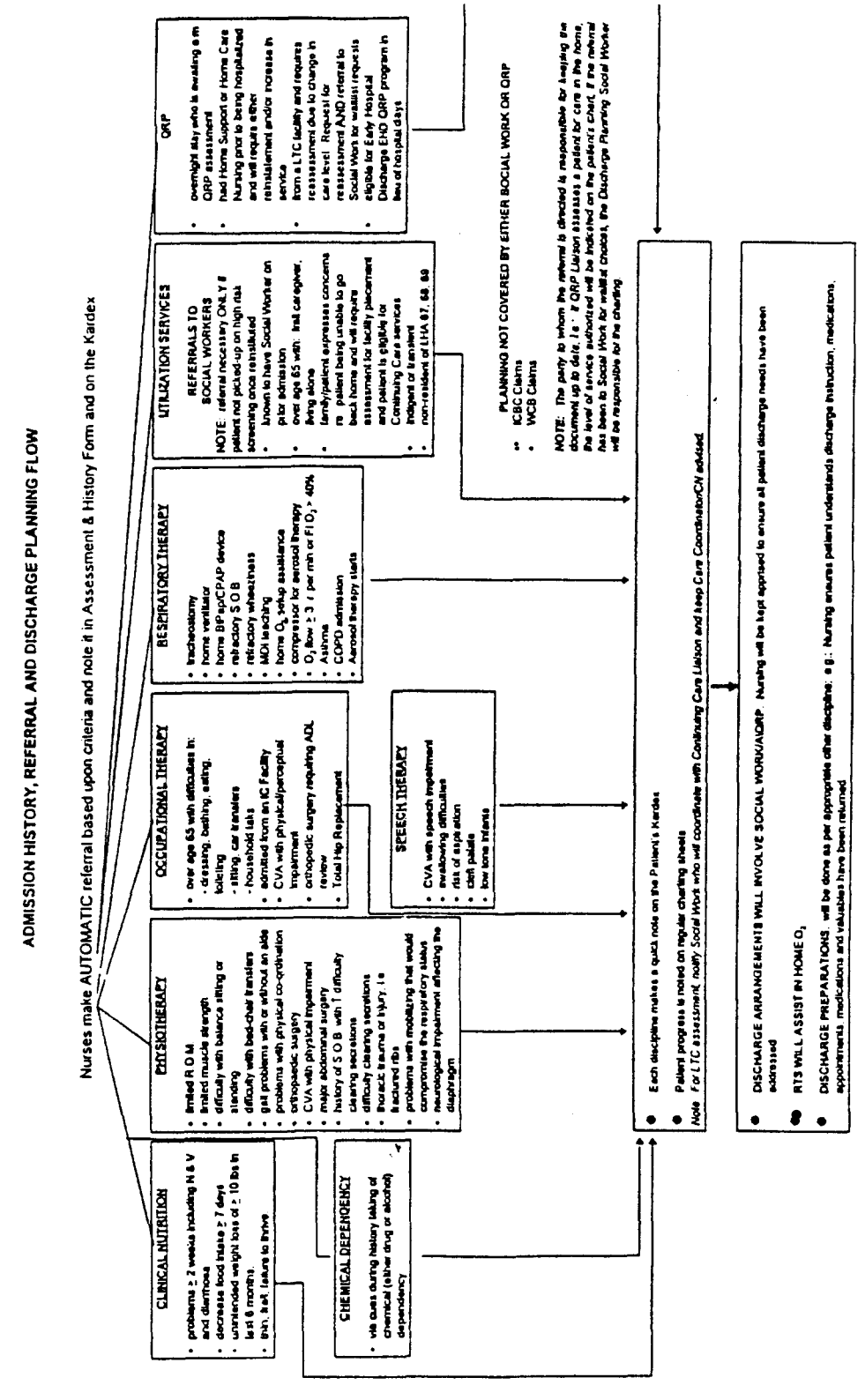
Many people underestimate their post operative recovery period and we encourage patients to make arrangements "expecting" that they will need assistance with washing, dressing, preparing meals, housework, etc. for the first few days at home. Also expect that you will have difficulty doing errands outside your home for the first few weeks, so these should be done prior to your surgery.

Date: _____ ***Signature:*** _____

Comments: _____

_____

Appendix I Discharge Planning Flow Sheet



Endnotes

[1] Use of pronouns to reference nurses and nursing (we, our, / they, their) presented a challenge during the writing of this work. As a nurse I wanted to include myself and write from a position of "sisterhood" with other nurses. I tried to use the pronouns "we" and "our" to refer to nurses' activities and to nurses' troubles. However, this pronoun use became unwieldy, as I also need to write of myself as observer and analysist. For consistency of word use and for ease of reading I decided to use they/them/their in my general use of pronouns when referencing nurses and nursing. Nonetheless, as a social actor in the drama of health care reform and hospital restructuring I am fully implicated in the practices this research uncovers. I make no claim to stand "outside" the subjectivity of my position as a nurse (or my position as researcher), and indeed use my "insider" knowledge about how things work as a resource, as "data" that contributes to the analysis and argument I build. I rely on the rigor of institutional ethnography and the methods it directs to ensure I am firmly located "on the side of" nurses-in-direct-practice.

[2] Throughout this dissertation I occasionally use the language of war using metaphors such as "*front-line nurses*" to refer to nurses in direct practice. This metaphorical language is useful to emphasize the *materiality* of the conditions of nurses' everyday/everynight work. It is also my view that war metaphors forefront the challenges nurses face when they work to subvert the institutionalized knowledge about nurses and nursing that, constructed from a ruling position, does not hold the relevances of nurses and their patients. (See Campbell and Gregor, 2002, p.124 for an exploration of the responsibility for institutional ethnographers to contribute to Smith's activist project).

[3] For example, the story of a 78 year old woman being interviewed on CBC radio who explained how nurses had woken her up in the middle of the night and asked her to arrange a way to get home. Apparently her bed was needed for an incoming patient who was acutely ill.

[4] Clinical update is a rather sporadic component of my teaching practice. Generally I arrange to do one or two days of clinical update when I am preparing to take students into an area of practice that is new to me. Nurses in practice agree to accommodate my presence and to "orient" me to the ward. When I realized the analytical usefulness of my experience I obtained consent from the nurse I had been working with to use our experience as data. She also kindly consented to be interviewed.

[5] This "External Nursing Review" was one of eight formal reviews conducted at the hospital between 1994 and 1998. The External nursing review referenced here was commissioned by the hospital "as a followup to a restructuring of the nursing units in 1995/1996". The review was conducted by a privately run group of nursing consultants (Nursing Review, June 19th, 1996).

[6] Key members of NUC continue to meet on an ad hoc basis, for instance when one of the original members was invited to present a brief to the federal Romanow Comission on Health Care and Costs (2001).

[7] My family members and I found we had to get to the hospital very early in the morning, before breakfast, in order to get any information about Hannah's condition. The neurosurgeon who was overseeing Hannah's care regularly completed his rounds at this time of the day.

[8] Many nurses I talk to are supportive of programs to reduce the length of time patients spend in the hospital. Armstrong, Armstrong, Bourgeault, Choiniere, Mykhalovskiy and White (2000) quote many nurses who, despite their consternation about what is happening to their ability to produce a competent practice, support the underlying foundations of health care reform. For example, this quote from a community nurse who, in spite of her concerns about some of what she observes happening when patients get sent home 24 hours after a mastectomy, is supportive of the practice. She sees patient teaching as a way to resolve the problems she is encountering:

> I think it is wonderful that patients come out of the hospital sooner. I think community care is great. But I don't think we're preparing them. I think maybe we should have . . . something that specifies exactly what they are

going to need after, because many people are home alone in this situation (p. 69).

[9] In contemporary professions "competencies" and "competency-based" practices are part of a sophisticated documentary form of practice that is highly contradictory (Jackson, 1995). Here, and throughout this dissertation, I use the term "competence" carefully due to the fact that references to "competence" now call up accountability practices that have been embedded in the institutional governance of competence and competencies.

[10] For example, in the "Vancouver acute organizational chart" (May 2003) of the Coastal Health Authority, administrative services for "finance, health records, human resources, information systems, professional practice, risk management and support services" are organized to serve four hospitals. They appear on the organizational chart as "Corporate business supports".

[11] The Canadian Institute of Health Information (CIHI) is "A pan-Canadian not for profit organization working to improve the health of Canadians and the health care system by providing quality, reliable and timely health information" (CIHI, 2003, p.1). The organization was established in 1994 through the amalgamation of the Hospital Medical Records Institute, the MIS Group and the specific health information programs from Health Canada and Statistics Canada.

[12] In March 2001 the Canadian Institute of Health Information distributed a lengthy report on The Financial Management of Acute Care in Canada: A Review of Funding, Performance Monitoring and Reporting Practices (McKillop, Pink & Johnson, 2001). They identified eight funding methods that were classified as "population based, facility based, case mix based, global, line-by-line, policy based, ministerial discretion and project based" (p.15).

[13] HMO's refer to private (for-profit) insurance companies and their partner "provider" corporations (hospitals, laboratories, diagnostic centres, home-care agencies, group physician practices and so forth). Preferred Provider Organizations (PPO's) are similar to HMO's that "offer subscribers several choices from panels of physicians and hospitals" (Burgess, 1998, p. 16). HMO's and PPO's are both considered "managed health care plans" which focus on new methods to of funding health care to "conserve resources"(Burgess, 1998, p. 16).

[14] Designating professionals to "home programs" apparently sustains a reporting framework for the professional. However, in the proposed new programs a professional's time may also be "negotiated between the 'home' program and other programs" (NRGH, integrated health programs, 1998, p. 5).

[15] In 1994 as part of Canadian health care reform mandated by Canada's health ministers the Canadian Institute of Health Information (CIHI) was formed. This institute is a national organization responsible for "developing and maintaining the country's comprehensive health information system" (CIHI 2000). Since its inception, the CIHI has introduced various approaches to gather and monitor "bed utilization" practices in Canadian hospitals.

[16] Discussing texts and their reproducability as important constituents of ruling relations Smith (1999) discusses how facts and truths generated in textual "hyper-realities" may be operated and acted on as though they were "real". She observes: "Reproducability constitutes a 'reality' corresponding to the circulation of the (printed) text. For example, the notion, and practice, of the replicability of scientific experiments relies on the interrelations between the theories, categories, quantities, etc., of scientific discourse and the standardization of laboratory technologies that reproduce as 'the same for all practical purposes' (though, of course, they are not the same) the local actualities that the theories, categories, and measurements account for" (Smith, 1999 p. 86).

[17] Length of stay is planned prior to admission. Patients are informed about how long they will stay in the hospital and are expected to make arrangements for going home at the allocated standardized discharge time. (At this research hospital patients are asked to sign a preadmission agreement (Appendix H) that

commits them to making the necessary arrangements required in the home. Patients are advised that their surgery may be cancelled if they fail to comply. The standard discharge time is developed based on peer hospital benchmarks for similar surgeries. The development of benchmarks is discussed in greater detail later this chapter.

[18] Note that this system allows hospitals to by-pass health professionals' efforts to control admissions. See Campbell (1992) for insight into nurses' struggles over patient admissions.

[19] "Alternate level of care" (ALC) provides a means for screening patients related to whether or not the care provided *could* have been provided in an "alternate" as opposed to "hospital" setting. ALC is discussed in more detail later in this chapter.

[20] See Mykhaloviskiy (1995) for a more detailed discussion about how physicians' and surgeons' resistance to reforming their approaches to care is being managed through discursive practices of health services research.

[21] Nurses at the NUC meeting talked about how difficult it was for them to arrange to have dying patients moved into private rooms or to have patients who were having trouble sleeping moved out of rooms where a roommate snored loudly. They were critical of the amount of authority that the bed utilization clerk held in relation to decisions to move patients throughout the hospital. They felt constrained in their ability to accommodate patient care.

[22] I use the term "unisex" here as a term to talk about the elimination of the distinction between "male rooms" and "female rooms". Rooms are now "unisex". Another term I considered using was "co-ed" to mark the move away from same sex accommodation.

[23] In Chapter Five I explicate in greater detail how the ALC designation appears on nurses informal work sheets and is used by nurses as a "diagnosis" to guide patient care.

[24] George Smith (1995) cites Hofstadter (1979) when he discusses the idea of recursivity and uses the term "nested" to talk about this phenomenon of social relations. Smith uses an example of "Russian dolls inside of Russian dolls" to emphasize how "a story inside a story . . . is part of a larger story and therefore has something of the same form" (p.33).

[25] The seven defined dimensions are: "1.) Respect for patients values, preferences, and expressed needs; 2.) Coordination and integration of care; 3.) Information, communication and education; 4.) Physical comfort; 5.) Emotional support and alleviation of anxiety; 6.)Involvement of family and friends; and 7.) Transition and continuity (Gerteis et al, 1993, p. 5 -11).

[26] The use of the word "theorized" here is taken from Smith's (1990) figure 6.1 "The actuality-data theory circuit". In this diagram Smith depicts the "work if a professional intelligentsia articulating data to the social scientific or psychological discourse – elaborating theories and conceptual schemata" which form a feedback loop into bureaucratic and professional procedures appearing as "operating schemata" in the production of factual accounts (p. 148).

[27] In Chapter Six I develop an analysis about patient satisfaction surveys as one of a number of "enforcement strategies" that are used to organize the compliance with, and support of, practices of restructuring.

[28] See also Rankin (2003) for more detail about how the text-based management practices of patient satisfaction obscure the actual experiences of nurses and patients and how health management technologies of patient satisfaction insert a particular "way of knowing" about health care that refutes other, differently situated claims.

[29] ALC, discussed in Chapter Four is a way of categorizing patients developed at the Canadian Institute of Health Information (CIHI). An ALC patient is defined as "a patient who no longer requires acute care but continues to occupy a bed for any reason" (CIHI, 1997). As noted in chapter three, the ALC term, referred to in the case management literature as "inappropriate days" or "lag days", references patients who could have been discharged or transferred from hospital sooner than was actually done.

[30] In one hospital, the ADT computer generated bed map was used on the doctor's board, at a smaller hospital, the doctor's board was written out daily by the night nurses.

[31] The questions, discussed earlier in chapter three included: "Why is it important to identify ALC days?", "Who identifies ALC?", When is ALC documented on the patient record?", "Does ALC status mean that the patient must begin to pay for treatment?", "Does ALC designation affect the Resource Intensity Weights (RIW's)?", "How does the Health Ministry use ALC data?" (CIHI Bulletin, May 28th 1997).

[32] See Mykhalovskiy (2001) for elaboration on the impact of health science research on Canadian hospital reform. Mykhalovskiy defines health science research as " a highly applied multidisciplinary field of research that addresses the structure, process, delivery and organization of health services" (p.269).

[33] Later, in the following chapter, I explicate the social organization of nursing's new front-line-nurse-leaders.

[34] Generally, in "pure" clinical pathways, resources are devoted to hire nurses to conduct chart audits. These nurses track and categorize the "variances" when patients "fall off" the pathways. These money to conduct these sorts of chart audits was not available in this limited pathway initiative.

[35] It is interesting to underscore that many hospitals have entirely deleted the designation of "nurse" in the new titles for front-line-nurse-leaders. Also, while in the early era of restructuring there was a trend to allow non-nursing professionals to these positions, in recent years most of these positions are occupied by nurses. It is important not to lose sight of how, despite the technologies developed to standardize nursing practices, nurses are still relied upon and are uniquely qualified to organize and provide nursing care.

[36] In 2003 staff nurses who are designated "in charge" are paid a small dividend of $1.25 an hour.

[37] Across hospital sites there is no consistency related to whether nurses in front-line-leadership are unionized or "out of contract". The trend is to move these positions out of nurses' unions and make them more explicitly managerial.

[38] See Campbell (1988, 1992) for an in depth analysis of "workload indexing", a technology introduced during the 1980's that are used to produce "units of need" in patient which are calculated to determine the number of nursing hours required.

[39] The responsibility for family members is becoming increasingly complex. Glazer (1993) notes that

> Teaching patients is a traditional home health nursing responsibility, but much of the content used to emphasize wellness. Today, what is taught is far closer to professional nursing than before. The content of what much be taught to patients and their caregivers is so complex that home health RN's take special courses. Specialists are brought into home health agencies from the hospital to teach the new techniques: intravenous chemotherapy, the use of catheters and lines, and apnea monitoring (p. 163).

Despite the increasing complexity of home nursing, the system for connecting patients and their families into the home care services remains a somewhat fragile and fallible link. The fallibility of this system was evident in Nurse Rushing's (Chapter Five) observation when she said "you just kindly bundle them out the door and keep your fingers crossed that home care will catch up with them".

[40] In Chapter Seven I develop a more detailed argument about how words from the nursing discourse are commandeered to develop nurses' business-like organizational consciousness. I identify a "double-sided" use of language that is professionally sanctioned.

[41] This competitive milieu is generated within a model that purports to value teams and "team-work", while at the same time it pits one department against another to "haggle over" patients who are deemed inappropriate candidates for hospital care.

[42] In their paper *Increasing Patient Satisfaction: A Guide For Nurses* Messner and Lewis (1996) situate their instructions within an understanding of Continuous Quality Improvement (CQI) requirements explaining how: "these concepts are woven throughout the book to demonstrate how a CQI culture is synonymous with empowering all levels of staff to provide a quality product" (p.xiv). The authors describe strategies for nursing activities that improve satisfaction ratings. Patient education directed towards achieving "healthy behaviors, a timely discharge, thereby saving health care dollars (p. xiv)" is the focus of an entire chapter. Staff's "warmth and hospitality" is the focus of another chapter.

[43] For Smith (1999), discourse is an ambiguous term that, among linguists, has been used to discuss both talk and writing. She maintains

> There is a distinction to made, at least for the sociologist, between speech genres which are characteristic of definite forms of work organization – the shop floor or the boardroom – and those of the social relations mediated by texts that I've called 'the relations of ruling'. Bakhtin (1986) deploys the notion of primary and secondary speech genres to make this distinction – secondary speech genres corresponding closely to the latter. Foucault, particularly in his *The Order of Discourse* (1981), uses the term in a rather more specialized sense, as those extended text-mediated conversations which constitute a "conceptual terrain in which knowledge is formed and produced" (Young 1981: 48). (1999, p 237 n 2).

In this chapter, I rely on Bakhtin's (1986) unravelling of "primary" speech genres to analyze nurses' speech during interviews and "overheards". I then use Smith's (1999) expansion of Bahktin's ideas to develop my argument as I analyze the professional publications of nurses' textual discourse – what Smith (1999) refers to as T-discourse. This analysis uncovers the ruling relation of efficiency, as a nursing interest.

[44] Nurses' referencing "workload" and "overflow" in the communications they use to accomplish the materiality of their work is an example of a managerial term that has become embedded in nursing lexicon. Later in this chapter I describe the utility, to managers, of embedding managerial terms into nurses' everyday lexicon.

[45] Balbir Sandhu RN PhD is a Quality Assurance Counsellor at a hospital in Quebec. Andre Duquette RN PhD and Suzanne Kérouac RN, MN MSc are both associate professors at the Université de Montréal.

[46] When referencing institutionalized programs of Patient Centred Care I use capital letters – as opposed to the lower case lettering I use to refer to how nurses might traditionally discuss patient centred care as a component of optimum nursing practice.

[47] The professional discourse I am referring to encompass the journals that nurses subscribe to as a component of their professional registration and the clinical/professional journals that are nurses would reference to inform their practices with patients. My analysis does not extend to nurses' academic/scholarly discourse where nursing itself is theorized.

[48] In my field work, the re-designation of shoulder surgery –rotator cuff repair – into the ambulatory care program (Chapter Four) provided an instance of how more and more surgeries are being designated as ambulatory care procedures. In contemporary hospitals "day-surgeries" represent the largest proportion of surgical procedures being performed (CIHI, 2003).

[49] One nurse I interviewed early in the inquiry explained how difficult it was for her to: "look into the eyes of this young fellow, who had probably just had the worst day of his life, and tell him 'sorry we have to move you because we're getting another admission and you're the one they've picked to go downstairs'".