NURSES AND THEIR WORK IN HOSPITALS:
RULED BY EMBEDDED IDEOLOGIES AND
MOVING DISCOURSES

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by
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ABSTRACT

Nursing originates from societal beliefs about women’s roles of self-sacrifice and obedience situated within a history of patriarchal control. Unfortunately, these ideologies continue to influence and shape nurses’ work in hospitals. Within the literature, several dominant discourses construct hospitals and nurses’ work in hospitals as chaotic and challenging while nurses are conceptualized as stressed and fatigued. Overcrowding, increasing patient acuity, budget constraint, and chronic understaffing are only some of the issues nurses face in their every day and night work. Because of these problems, nurses are expected to care for patients in the hallways; manage with minimal staffing; and simply absorb the work associated with acutely ill patients. Nurses actively participate and take up these discourses as their work. Patriarchal assumptions and nurses’ endless compromise and accommodation have resulted in the normalization of hospital problems as just part of nurses’ work. Prevailing ideologies and institutional discourses make invisible, and taken-for-granted, how this work contributes to sustaining the hospital’s power. External relations contribute to influencing and organizing nurses and their work. Using institutional ethnography and a poststructuralist perspective; this research relies on my experience, historical research, participant observation and interviews to reveal how institutional discourses have framed nurses’ work in hospitals and how nurses actively participate in perpetuating and vivifying them.
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DEDICATION

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CHAPTER 1: INTRODUCTION AND SIGNIFICANCE

Throughout history nurses have faced adverse working conditions, an aspect of their work that remains remarkably unchanged today. The social and economic effects of the prevailing historical and political conditions influence nurses’ work in contemporary hospitals. Nursing originates from societal beliefs about women’s roles of self-sacrifice and obedience situated within a history of patriarchal control. Nurses, mostly women, work in hospitals or acute-care institutions that are coordinated and organized by a patriarchal ideology embedded within military and religious history (Canadian Institute for Health Information [CIHI], 2006; Canadian Nurses Association [CNA], 2008; McPherson, 1996). The care of the patient is inherently part of the nurse’s role; yet, situated in the hospital hierarchy, nurses remain largely unheard in health-care delivery decisions. Traditional roles and the patriarchal influence continue to be woven through nurses’ everyday work lives. Virtually all these discourses have affected nurses, but nothing is more basic than the influence of their work environment. The term nurse will be used throughout this dissertation in reference to the registered nurse who is the starting point of this research.

Much of the nursing literature concludes that adversity is simply a part of nurses’ work, while stress and ill health are symptoms associated with the work. The literature also describes nurses as stressed, burned out, resilient, or not being able to cope with their work. The implicit theme is the ability of nurses to get through whatever conditions they face in their work and work environment. Few authors discuss how this has come to be the case. How did chronic understaffing and caring for acutely ill patients in the hallway become part of nurses’ work? It is no exaggeration to say that nurses’ work is shaped by
ideologies and discourses of efficiency, a patriarchal hierarchy, and a scarcity of staff and resources.

Nurses unknowingly adapt to competing agendas and shifting priorities because they are subject to institutional demands. These include surrendering to budget pressure, caring for increasingly acute patients, managing the overcrowding of patients, working chronically short staffed, and working off-peak hours without support and resources (Hamilton, Mathur, Gemeinhardt, Eschiti, & Campbell, 2010; Health Regions, 2010; Rankin & Campbell, 2006). Nurses are constructed as stressed, burned out and, more recently, through the media’s rhetoric, as grossly overpaid poachers looking for more overtime shifts (Braithwaite, 2008; Cowan, 2011; DiGiacomo & Adamson, 2001; Edwards & Burnard, 2003; McGrath, Reid, & Boore, 2003). All of these, the authors assume, contribute to increased sick time and to burned out, stressed nurses (Aiken, Clarke, Sloane, Sochalski, & Siber, 2002; CIHI, 2006; McVicar, 2003). Is this a consequence of doing woman’s work in a social and professional hierarchy?

Social relations connect and coordinate nurses’ activities and “manifest in puzzling events that appear to not make sense or that suggest that decisions are being made over which people in the local site have no control” (Grahame, 1998, p. 351). There are several historical and socio-political forces that shape nurses’ work places. Since the majority of nurses work in hospitals, which were the local sites for this research, they provided the context in which to best understand the social organization of nurses’ work. Nurses’ work continues to be governed by unseen power relations, and by organizations and regulations that have developed over time or, as Smith (1987, 1999) says, relations of ruling. “Ruling takes place when the interests of those who rule dominate the actions of
those in the local setting” (Campbell & Gregor, 2002, p. 36). This research seeks to explain how nurses’ work is unknowingly situated and organized within the ruling relations of acute care.

Oddly, the historical context and the social space of acute care have been overlooked in the majority of the nursing literature. “Why hasn’t more attention been paid to that research, and to nurses themselves, who continue to declare that their workplaces are understaffed and their workloads too heavy?”(Unruh, 2008, p. 62). My research seeks to understand how these taken-for-granted forces have organized and coordinated nurses’ work. “Nursing history, similar to women’s history, requires many approaches and even several feminist approaches to facilitate an understanding of nursing’s historical and present position in healthcare and society” (Melchior, 2004, p. 341). Unknowingly, nurses have created a culture of acceptance with the expectation of adversity in acute care. The ideology of selfless service and self-sacrifice is historically embedded and continues today. Thus, the first research question that guides this study is: What are the ideological discourses and discursive forces surrounding nurses who work in contemporary health care? And, second, how do the ideologies and institutional discourses rule and shape nurses and their work?

Deconstructing and critiquing discourse is helpful in understanding how “discourse works to legitimize and contest power” (Lather, 1991, p. 89). Clearly, an exploration of the inherent problems in the nurse’s workplace needs to be undertaken. What is less understood are the assumptions and discourses that underlie these conditions, the values that are attached to nurses’ work that perpetuate unsatisfactory or, in many cases, intolerable working conditions” (McIntyre & McDonald, 2010, p. 299).
Thus employing “a method of inquiry that examines how ruling takes place” within nurses’ work can contribute to understanding how problems emerge (Campbell & Gregor, 2002, p. 39).

After reviewing various research approaches, I found institutional ethnography (IE), a feminist-inspired approach, particularly suited for inquiry into the organization of women’s experiences (Smith, 1990a) and for understanding nurses’ work. IE begins “in the actualities of the lives of some of those involved in the institutional process and focus(es) on how those actualities were embedded in social relations, both those of ruling and those of the economy” (Smith, 2005, p. 31). I begin with nurses as the starting point. “When you start with the people and what they are doing and trace out interconnections, you find extended relations and work processes that traverse organizational or subdisciplinary boundaries” (McCoy, 2008, p. 703). IE contends that in the production of knowledge, ideology and discourse constitute essential parts of what we need to analyze in order to understand both social relations and ruling relations. These relations signal that this research is about coming to know the social, the power, and the organizational effects that frame nurses’ work. This work reveals the ruling relations that organize nurses’ work in acute care. Nurses must become aware of how they have been ruled. The knowledge created from this research will “extend rather than replace our everyday knowledge of the world” (McCoy, 2008, p. 705). Thus, my overall aims were to understand how nurses work within the conditions in acute care and to uncover the contextual or unseen discourses that support or limit their practices. “There must be sufficient critical awareness of the issues and operating ideologies to make resistance the norm rather than simply the maverick behaviour of an individual” (Varcoe & Rodney,
2009, p. 138). My hope is that this research will provide insight into nurses’ work and their workplaces regarding the competing discourses affecting their everyday/night work by recognizing what they are participating in.

Recently, institutional ethnography research has become increasingly evident in nursing literature. Rankin and Campbell’s (2006) research, highlights how the effects of the health-care reform impact nurses’ work. While the effects continue to influence nurses’ work, new rulings are penetrating that work. Although this study draws parallels from the work of Rankin and Campbell, no other study to date has sought to understand how nurses’ work is unknowingly influenced by the past and is situated in contemporary acute care. Thus, this work will contribute to advancing the understanding about nurses’ work and create awareness for nurses, hospitals, nursing schools, and policy makers.

**Statement of Problematic: The Lens of the Ruled Researcher**

“Dorothy Smith has insisted that investigation of the everyday world must begin in a particular orientation of the researcher’s interest and attention” (Campbell & Gregor, 2002, p. 45). IE starts with personal experience. For many years, I have witnessed and been a part of the adversity that is considered part of nurses’ work. My career began in 1984, a time when nursing positions were scarce. Thus, my first job was not as a nurse but as a nurse’s aide adhering to the strictly organized bathing and bowel routines of my patients. Such routines and other entrenched rituals dictated how my work was done. I had been prepared for the physical nature of the job; however, the fundamental demands of caring for over 50 bedridden patients in an eight-hour shift had not been covered in my nursing education. The military influence was evident as we stood in line before and after each shift waiting to punch our timecards. As nurses, we followed without question the
hospital routines that had not changed in years. I knew from my nursing education that mitered corners and the ability to bounce a quarter off my perfectly made beds were important. Besides caring for the patients, other domestic tasks such as folding the laundry and cleaning the floors were routinely part of our work. While I was not taught these skills in nursing school, I was a woman and these just became part of my duties.

By 1989, full-time positions in urban centers continued to be difficult to find but fortunately I landed a casual nurse position at the Pasqua Hospital in Regina, Saskatchewan. With the continued abundance of nurses, holding a casual position literally meant begging for work or staying at home and waiting for the phone to ring, hoping that someone would phone in sick or take time off. Collective union agreements at this time did not have stringent seniority policies, which meant being controlled by the power of the scheduler who often gave nursing shifts to those who gave her gifts. We did not think to question authority and, as good women we did our work, often stayed overtime without requesting additional pay. Nice girls get along and do not complain.

Physicians would come and go at all hours of the day and night and, as nurses, we would scramble to meet their every need. Many of us feared that we would not be able to answer their questions or, worse yet, as some of us had experienced, we would be humiliated in front of a patient or other colleagues. I quickly learned which physicians not to question. The head nurse would scurry around with her clipboard attending to the physicians and then organize us to quickly address their needs. I recall on several occasions, physicians doing procedures that required instruments that were not kept on the unit, which meant ordering them and sending a nurse running to gather the equipment. You were not to keep a physician waiting.
Eventually, I was put in charge of the nursing unit. This entailed coordinating the patients’ information for the physicians and organizing admissions and discharges. As charge nurses, we were privy to the physicians’ social lives since we were told not to disturb them during football games, the symphony, or family celebrations. Much of our work was dedicated to organizing and coordinating hospital business while making the physicians’ day easier. We were constantly reminded to complete our work during our shift hours, regardless of the circumstances, or we could expect to be questioned about our organization and priority-setting skills, two important aspects emphasized in nursing school education. The physiotherapist would come in and complete the initial consult. We were expected to carry out the prescribed physiotherapist’s regimen. I had mastered bed making so why couldn’t I be organized to care for 10 patients, four who needed to be bathed and fed and two who needed to be walked twice daily.

Health-care restructuring of the ‘90s led to downsizing and mass lay-offs of nurses. We were expected to look after more patients with fewer nursing staff. Being organized meant caring for 10 clients with different needs, giving their medications at the same time, taking them to their tests in different areas of the hospital, and admitting and discharging patients while providing the education necessary for them to manage at home.

For me, the restructuring resulted in being bumped to a part-time job and a decision to pursue operating room nurse education. That decision led to a lesson in experiencing a ruled operating room. As one of the six students who were accepted, little did I know that we had entered into a world controlled by physicians and served by nurses. Since being a servant was not how I had envisioned my career, I finished the
training but never worked in that area. The closure of the Plains Health Centre brought about a major reorganization of nursing areas in the hospital which, for me, resulted in the new position of nurse educator. Ironically, part of my job was to facilitate much of the amalgamation, which had been opposed by many staff. Unfortunately, my new role was not well received by my colleagues given that many nurses had lost their jobs.

After 20 years of nursing in acute care, I marvel today at how little our work as nurses has changed and how acute care continues to be plagued with many of the same problems I encountered. Workload issues, overcrowding, and the nursing shortage are only some of the adversities that still linger (Saskatchewan Union of Nurses [SUN], 2009). While I have been teaching nursing since 2000 and no longer work in acute care, I teach in that setting. As I walk through the hallways of the hospitals, I cannot help but notice the physicians’ lounge, recalling that the nurses’ lounge closed years ago to make room for supplies; I see, too, that the managers’ offices are situated away from the nursing units. Last, but certainly not least, I notice the close proximity of the physicians’ and managers’ parking lot adjacent to the hospital as a nurse runs in from the staff parking which is considerably further away. What else have I not seen?

My years of experience working as a nurse in acute care have provided evidence for the preliminary fieldwork related to the identification of the problematic for my research. “The notion of problematic assists the researcher to identify her own stance in relation to the inquiry” (Campbell & Gregor, 2002, p. 46). To add to my experiences and observations, Smith (2005) suggests identifying the problematic by talking to the people within. The nurses, all women, with whom I spoke identified several challenges in their work in acute care. These adversities included a chronic nursing shortage that has
resulted in workload issues and excessive work hours for nurses; bed shortages resulting in patients being cared for in the hallway; and, most notably, nurses’ work that, for the most part, is directed by administration and physicians. The nurses, however, did not discuss how these experiences occur. They did not discuss what is taken-for-granted. They did not discuss how their work is ruled by invisible powers. My concern is not what the nurses do, but with the social aspect of their doings. Nurses are embedded in many forces that influence their work and are able to provide “experiential accounts produced by people whose knowing is discursively organized” (Campbell, 2006, p. 92). What are the unknown forces that rule nurses’ work? That is the problematic.

“Problematics can emerge from the ethnographer’s own life…some of the best institutional ethnography emerged out of activism” (Walby, 2005, p. 162). While I did not start this process with the goal of activism, I believe that this research will uncover how nurses’ work is ruled by many unknown forces and, in so doing, will create an awareness that could potentially change that work. Campbell and Gregor (2002) believe that IE researchers “cannot stand apart from what they know and what they learn about the world” (p. 23). My interest for this research began from a desire to understand stress in nurses’ work and the process of becoming a resilient nurse; it evolved to seeking to understand how adverse work conditions came to be just a part of nurses’ work in hospitals. It is apparent that

There is not yet an adequate exploration into the substantive layers of meaning about what exactly is lacking for nurses and/or lacking within nursing practices, especially practices in hospital settings where efficiencies and high patient acuity generate intense activity and pressure to limit practice to the performance of tasks. (Mitchell, 2003, p. 219)
Years of experience as a nurse and a woman situated within a more often than not adverse work environment led me to the need to understand something more about nurses’ work.

Thus, based on my experiences and where I am situated today, my assumptions include, but are not limited to, nurses in contemporary hospitals unknowingly work under the influences of military and religious history; an unknown patriarchy rules much of nurses’ work in acute care; nurses’ work is misunderstood by society; hospitals apply business models to a human health-care system; nurses believe that adverse conditions are just part of their everyday/night work; nurses’ work is entangled within insidiously adverse conditions ruled by unknown powers; and finally, nursing education contributes to the socialization of nurses in the maintenance of a selfless ideology. I also assume that I have been ruled, mostly unknowingly, which serves to provide the vigour for this research. “Experience itself is organized through relations of ruling not visible to individual knowers and is, therefore, politically constituted as well” (Naples, 1999, p. 49). How do traditional roles and the patriarchal influence continue to be woven through nurses’ everyday/night work lives?

Nurses’ work in hospitals is coordinated by an embedded patriarchy and is organized through a militaristic discursive structure that follows managerial and efficiency discourses led by selfless ideology - things that I never thought about during my work, while admittedly participating in, and contributing to, them. While I understand that my worldview is limited to my history and experiences, my interest for this research is truly dedicated to raising awareness about nurses’ work and ultimately improving that work.
An Embedded Problematic: Nursing in Acute Care

Contemporary health care has evolved through a history of economic, political and social influences within which it operates. Within this system, acute-care institutions or hospitals are the largest part and represent the single largest category of health care spending (CIHI, 2008; Health Canada, 2005). Registered nurses, most of whom are women represent the largest group of professionals who provide health care in hospitals (CIHI, 2008; CNA, 2008). Hospitals are organized by a hierarchy embedded within military and religious history. “From its inception modern nursing has had a self-conscious and limited speaking voice embedded in nineteenth century notions of the good woman” (Alavi & Cattoni, 1995, p. 344). Nursing originates from societal beliefs about women’s roles of self-sacrifice and obedience and is situated within a history of patriarchal control. The reliance of virtue in nursing has changed little from early days “as women have gained greater social, economic, legal, and political power” (Nelson & Gordon, 2006, p. 19) reinforcing the social script of “traditional gender dichotomies in which doctors, the knowledge workers, save lives, while nurses give comfort and kindness” (Nelson & Gordon, 2006, p. 22).

The Early Years: Nursing as an Extension of Women’s Roles

In early days, hospitals did not exist. Following Confederation, a number of charities were established across Canada to meet the health care needs of individuals (Agnew, 1974). In 1867, Saskatchewan’s health care was controlled by private, charitable, or religious groups (Leeson, 2002). Patients and families paid for private health care visits; however, if payment was not possible, charitable reconciliation was arranged. At the time of the Northwest Rebellion in 1885, public hospitals were
nonexistent and health care was performed in people’s homes. Traditional remedies were used to treat the sick as scientific discoveries were nonexistent and physicians, mostly ex-military, were few (Robinson, 1967). Nursing was provided to the sick by neighbours and family members, mostly women, “who had no training and usually their only qualification was a sympathetic desire to help” (Robinson, 1967, p. 8). As part of the unpaid domestic economy, nursing was assumed to be part of a woman’s role given her natural abilities. “Nursing was often taught by mother to daughter as part of female apprenticeship or learned by a domestic servant as an additional task of her job” (Reverby, 1987, p. 5). Influenced by their religious ideals, women extended their care practices from the family to the care of strangers. “Caring was difficult to see because it was most often provided by women, without formal training, to household members” (Armstrong & Armstrong, 1996, p. 101). The calling of womanhood was truly fulfilled when practiced at home (O’Brien, 1986). Women were considered to have a duty to care for others by helping the poor and suffering (McPherson, 1996). From early days, values of duty and domesticity became inherent in nursing.

By the late 19th century, local municipalities were forced to provide health care services as there were no federal or provincial structures in place. Thus, in 1889, Regina’s first hospital was established, a private six-bed hospital in the home of Mrs. Truesdell, a teacher who worked under a physician’s direction and “who liked to care for the sick” (Robinson, 1967, p. 12). With Regina’s population growing to 1800 residents, the need for health care services was growing. Thus, in 1896, public hospital services were established when the Local Council of Women organized a financial campaign and opened the six-bed Cottage Hospital, Regina’s first public hospital. The Victorian Order
of Nurses was commissioned by the attending physician to provide nursing care to the patients. The majority of nurses continued to work in private homes, unless they were members of the religious orders that provided most of the hospital care. Public hospitals provided free care for those who could not afford it. “Even when care was provided in homes or institutions by paid female workers or by the nuns, it was frequently assumed that women had no need to learn the skills for the job” (Armstrong & Armstrong, 1996, p. 102). Physicians imposed their model of health care because of their sex and class. From their inception, physicians viewed hospitals as separate and maintained their practice outside the hospital (Ashley, 1976).

Provincially, Saskatchewan was advancing from a fur trading community to farming, logging, mining, and the railway, which provided employment and economic growth. European settlers were rapidly moving into the province. The health care system was being shaped by the settler population and the diseases they brought with them (Coburn, D'Arcy, & Torrance, 1998). With the increasing number of sick patients, the Cottage Hospital grew to 14 beds, creating challenging work conditions for the nurses.

Coal oil lamps, well water to be carried, often upstairs, slops to be emptied, wood fires and a lack of equipment combined to frustrate the nurse in charge of patients, who had traveled long distances with gangrenous wounds and high fevers. (Robinson, 1967, p. 17)

By the end of the 19th century, disease, farming accidents, childbirth, and death overwhelmed the only two hospitals in Saskatchewan, highlighting the need for more hospitals in the province (Strong-Boag, 1991). “The emergence of the hospital system within the context of burgeoning industrial capitalism set the tone for a nursing force characterized by a unique blend of Christian dedication, Victorian femininity, medical
faith, and labour discipline” (Wotherspoon, 2008, p. 99). Caring for the sick at home shifted to caring for the sick in the hospital.

From its onset, nursing was subordinated to the organized medical profession and administrators within the hospitals (Coburn et al., 1998). Each municipality appointed a health officer who, besides writing a monthly report on contagious diseases, determined the need for more hospitals in the province (Robinson, 1967). Thus, the city of Regina replaced the Cottage Hospital and opened the Victoria Hospital, a larger 25-bed facility in 1901.

Internationally, through the influence of Florence Nightingale, nursing schools embedded with strict rules of obedience and military order were being established across Canada (Coburn, 1988). “Florence Nightingale and other nursing reformers were …instrumental in establishing more sanitary and professionally operated institutions” (Chappell & Penning, 2009, p. 145). Locally, influenced by the success of Nightingale’s nurses’ training schools in England and Canada, the health officer recognized the value of such education and pressured hospitals to establish schools of nursing. “Women’s inclusion in education, the franchise, public life and the labor market have been on terms designed to meet the needs of the individual men, unfettered by ties of motherhood, childcare and domestic labour” (Weedon, 1997, p. 2). With physicians in positions of power it was easy to convince hospital administrations to establish nursing schools. Economically, it would benefit the hospital, as the students would provide free nursing care during their training (McPherson, 1996). Nurses’ labour allowed hospitals to grow. Medical control prevailed in hospitals ensuring that nurses would remain subordinate.
Thus, hospitals became the site for nurses’ training and, in 1902, the Victoria Hospital opened Regina’s first school of nursing or Training School for Nurses as it was called (Robinson, 1967). Initially, formalized nurses’ education was not supported by all the medical community; however, over time, “medical officers agreed that nurses were logical and loyal allies in the emerging public health movement” (McPherson, 1996, p. 58). Curriculum focused on assisting patients, domestic services, and obeying physicians’ orders (Abel-Smith, 1960). Nightingale’s style of training was considered a reliable process for young women to become disciplined and obedient as good nurses. “Nursing training was rigid, orderly, and disciplined and students were overworked” (Reverby, 1987, p. 359). Physicians supported the apprenticeship schools as a means of gaining control over nurses’ labour (McPherson, 1996). The patriarchy prevailed because much of the education was done by the physicians, giving them control and power over what the nurses learned (McPherson, 1996).

Across the province, several training schools for nurses opened as hospital administrators realized the value of nursing students as disciplined, cheap labour (Ashley, 1976; Bassendowski, 2005a). Training schools were controlled and financed by hospitals. Apprenticeship-like training created a female hierarchy within the schools. Nurses’ training was driven by the “service needs of the hospital” (Reverby, 1987, p. 7), while students were disciplined and overworked. Orders were passed down from the nursing superintendent to the probationer student nurse. Nurses were educated to obey the matrons and were shaped into physicians’ handmaidens. Apprenticing nurses lived by many rules and were required to live in nurses’ residences (McPherson, 1996). Physicians
would come and go as nurses continued to be indoctrinated deeper into the paternalistic culture.

While in training, nurses received little nursing education as their practice was dictated by physicians’ instructions and the hospital hierarchy. The needs of the hospital took precedence over educational requirements, as a nursing student would spend weeks on the medical ward and not experience other areas of the hospital (Reverby, 1987). Education was considered secondary to the nurses’ work of feeding and maintaining the hygiene of patients; essentially, nurses were domestic servants. “Like mothers in a household, nurses were responsible for meeting the needs of all members of the hospital family—from patients to physicians” (Ashley, 1976, p. 17). The apprenticeship model perpetuated the paternalistic views of nursing held by society, hospital hierarchy, and the physicians of the time (Ashley, 1976).

Repressive education taught nurses to be subservient as they became increasingly more subject to physician and hospital control. “The role of the nurse in early days was not described in terms of patient care, but in terms of the proficiency with which she carried out the physician’s orders” (Keddy, Jones-Gillis, Jacobs, Burton, & Rogers, 1986, p. 748). Hospital administrators had deemed nursing as women’s work and suggested eliminating male nurses and replacing them with male orderlies who could perform duties considered unsuitable for females (McPherson, 1996). Selfless service and firmly established medical-and-hospital ruling dominated nurses’ work. Nurses were educated to not ask questions while their value was equated with their degree of helpfulness to the physicians. “They were restrained by the discipline which matrons had imposed on them
by their loyalty to their group and to their hospital, and by the spirit of uncomplaining
service which was taken to be the heritage of their profession” (Abel-Smith, 1960, p. 245). Although the suffrage movement received society’s attention and moved women
forward, nurses were not given the same consideration because many of them refused to
be associated with the movement or the feminist cause (Ashley, 1976; Way & MacNeil, 2007).

Locally, fiscal hardship caused the city to take control of Victoria Hospital from the
province in 1907, warranting a name change to the General Hospital. An expansion of
the General Hospital in 1912 increased its capacity to 108 adults and 40 children (Regina
Public Library, 2009). At the same time, another hospital was being established. After
purchasing the Park Sanatorium, two Catholic Sisters took over and cared for its five
patients; however, overcrowding necessitated a larger hospital. Thus, in 1907, the Regina
Grey Nuns Hospital was opened by the Sisters of Charity, who established a school of
nursing within the hospital at the same time. The nurses became members of the religious
order that provided care in the hospital (Robinson, 1967). The majority of nurses worked
in private homes because nursing students provided free labour in hospitals. Once
graduated, students were expected to leave and find work elsewhere (McPherson, 1996;
Robinson, 1967). Traditions from the army, the religious orders, and the influence of the
hospital patriarchy became embedded in nurses’ work.

Medical and hospital care continued to be provided at the municipal level. In 1916
the Saskatchewan government developed the Municipal Doctor System, a plan that
pooled municipal monies to develop more hospitals (Gelber, 2008). Additional increased
bed capacity at both the General and the Grey Nuns hospitals underlined the need for
more nurses; however, the majority of nursing care continued to be performed by nursing students or unqualified lay people (Agnew, 1974). Although patients were required to pay for health care services, the majority could not afford the cost and continued to rely on neighbours and friends to help in times of illness (Robinson, 1967). At the same time, nurses were attempting to organize as a profession; however the combination of dominating hospital practices, long hours of work, and societal beliefs about women made it difficult for them to advocate for change (Ashley, 1976). Most believed that a nurse’s main contribution to society was becoming a wife and mother.

**Years of Change: 1920-1960**

World War I marked the many noticeable contributions of nurses. The increasing demand for their services brought about the need for regulation and the establishment of professional organizations from the international to the local level (McPherson, 1996). “Nursing was one of the first professions that women sought to control and organize” (Mason, Leavitt, & Chaffee, 2007, p. 23). Efforts to organize nursing and to lessen the exploitation of nurses in hospitals were initially opposed by administrators (Ashley, 1976). Provincially, the Saskatchewan Registered Nurses Association (SRNA) was established in 1918, while federally, “several organizations united to establish the Canadian Nurses Association (CNA) in 1920” (McPherson, 1996, p. 63). Nursing associations supported, and were supported by, women’s groups. The advancement of women’s rights, including the vote for women in 1918, also influenced the agenda of legislation for the registration of nurses (McIntyre & McDonald, 2010). Many physicians were opposed to the organizations, as they wanted nurses to remain under their control. SRNA’s first 5 years were focused on “launching the new association on a foundation of
high principles and building an organization that would be flexible enough to meet changing needs” (Robinson, 1967, p. 52). Professional organizations gave nurses professional legitimacy and standards and established training requirements.

Following World War I, Saskatchewan experienced an economic boom as the agricultural sector and employment opportunities expanded. The 19th century social reform movement supported women who wanted to obtain more education. The Saskatchewan Election Act (n.d.) was amended and women got the right to vote (Leger-Anderson, 2006). “Medicine, which was gaining social legitimacy, was threatened by movements for female emancipation and education” (Nelson & Gordon, 2006, p. 17). Women entered nursing as one of the three female-designated options besides teaching and secretarial positions (McPherson, 1996). The majority of women who entered were unmarried “since nurses, like other female wage-earners, were enjoined to leave paid labour upon marriage” (McPherson, 1996, p. 116). Hospitals employed nurses who were single, divorced, or widowed and training schools would not accept married students. Although these working-class women attempted to exert control over their working conditions and the physicians with whom they worked, they remained within a subservient class (Reverby, 1987). The hospital patriarchy prevailed as women constituted a cheaper source of labour; nurses remained subordinate to doctors and devoted to the patient.

Nationally, questions were being asked about the theoretical and practical learning that occurred in hospitals (Bullough & Bullough, 1984). Faced with increasing responsibilities, low salaries, and long hours, nurse leaders realized the economic asset that training school nurses had become to hospitals. “Classes were often held before and
after students worked 12-hour shifts on the ward” (McIntyre & McDonald, 2010, p. 197).

In 1929, the Canadian Nurses Association (CNA) and the Canadian Medical Association (CMA) commissioned Dr. George Weir, Head of the Department of Education at the University of British Columbia, to study nursing education in Canada (Weir, 1932). After surveying and visiting schools across the country, Weir recommended several changes, all of which were considered radical for the time. Among them were a standardized baccalaureate nursing education program and a decrease in the number of hospital schools (Agnew, 1974; Beamish, 1970). However, with the advent of the Depression, neither hospitals nor universities could afford to create a new system of educating nurses (McIntyre & McDonald, 2010). Thus, the recommendations were not implemented until several years later.

The global economic depression and drought of the 1930s began to impact the Saskatchewan economy. The population had peaked at approximately one million in 1929, then between 1931 and 1941, 250,000 people left the province (Friesen, 1984). Unemployment increasingly affected everyone, including nurses. This prompted the SRNA to decrease the number of nurses training in hospitals (Robinson, 1967). Nurses continued to have little power within the hospitals. As competition grew for jobs, nurses became handmaidens to physicians as “they tried to become good nurses in order to obtain jobs” (Keddy et al., 1986, p. 747). Private-duty nurses experienced the downward turn first as patients were unable to pay for their services. “Lucky ones were employed in hospitals for general duty, some got a little hourly nursing, others, less fortunate, worked for board and room as domestic help or as a companion to the invalid” (Robinson, 1967,
p. 65). Some nurses accepted reduced salaries in exchange for job security; many others joined the Armed Forces which guaranteed job security (McPherson, 1996).

By the late 1930s, a renewed sense of optimism was taking hold across the province as economic conditions slowly began to improve. Government monies were allocated for health and education. Both the General and the Grey Nuns hospitals experienced expansion (Robinson, 1967). With the support of the SRNA, the University of Saskatchewan School of Nursing opened in 1938 and established an undergraduate program. The demand for nurses began to surface midway through the war as the number of patients in hospitals increased and others required care in their homes (Robinson, 1967). The expansion and demand for trained nurses came not only from the hospitals but also requests came to work in people’s homes, in clinics, in public-health sites, and in schools. As the need for nurses increased, a dire shortage of nurses was becoming apparent (Abel-Smith, 1960).

Efforts were made to address the shortage federally, provincially and locally. Nurses were recruited from other countries (McPherson, 1996). The nursing shortage resulted in an aggressive national campaign aimed at recruiting women to become nurses. Married nurses who had earlier been forced to leave nursing once they married were recruited and given a refresher course (Beamish, 1970). The recruiting of nurses was especially challenging as women took advantage of opportunities for better paying jobs. Efforts focused on recruiting students to nursing programs led to bursaries from the federal government and the Kellogg Foundation.

Nursing leaders campaigned to resolve the dichotomies between heterosexual pursuits and paid work by emphasizing that any woman could usefully train as a nurse and that training would enhance not only a woman’s marital prospects but also her skills at making a marriage successful. (McPherson, 1996, p. 191)
The female caregiver image prevailed and, while many nurses opposed it, others continued to believe that nursing was women’s work.

Locally, the nursing shortage created a crisis in the hospitals. SRNA made an appeal for emergency nursing service and inactive nurses were recruited to work in hospitals (Robinson, 1967). Hospitals sought government assistance to help with the growing shortage. The provincial government lowered the age of entry into nursing programs from 19 to 18 (Ad Hoc Committee on Nursing Education, 1965). The nursing shortage also prompted changes within hospitals. Hospitals allowed hiring married women, reduced the hours of the nurses’ work week, and increased their salaries; however, these steps did not affect the lack of nurses (McPherson, 1996). In 1946 SRNA, in collaboration with the Advisory Committee of Nurses’ Aides, established a training program for nursing assistants who would work in the hospitals. “It was hoped that these workers would find a useful and satisfying sphere of service in both hospital and community without adversely affecting the nursing services or the status of the registered nurse” (Robinson, 1967, p. 127). Nursing assistants shared responsibilities with nurses. Various other categories of ancillary hospital personnel were also created to assist with the increasing patient load and the limited number of nurses. The majority of nurses were now employed within hospitals situated in the health-care bureaucracy.

Nationally, post-World War II, the health-care system underwent a fundamental transformation as the federal government recognized health care as a legitimate area of involvement and spending (McPherson, 1996). Hospitals became a collection of specialized services; however, this expanding labour force caused hospitals to struggle to maintain financial stability. “As medical mastery of techniques in the cure and treatment
of disease progressed, an array of specialty areas arose, a great deal of what was once considered exclusively medical practice became a routine part of nursing practice” (West, Griffith, & Iphofen, 2007, p. 124). Nurses assumed more responsibilities while remaining subordinate in the hospitals.

Following World War II, the province witnessed many changes. The Liberal party that had been in power since 1905, with the exception of 1929-1934, was taken over by the newly elected Co-operative Commonwealth Federation (CCF) government in 1945. The CCF promised to develop a system of socialized medicine and therefore began to change the health care system. Prior to this time, health care was primarily privately delivered and funded. Health care had been provided for those who could pay and, although health insurance was available, yet many were left without health care (MacTaggart, 1972). The new system was intended to provide care for all Saskatchewan residents, regardless of their economic situation. The implementation of health insurance began in 1947 and initially included free services for specific groups (Friesen, 1984). In 1962, physician opposition to the new plan resulted in a 23-day strike which was resolved through major changes to the legislation (McPherson, 1996). Medical dominance was reinforced by the new system of Medicare since only physicians could be reimbursed for services (Burke & Stevenson, 1993). Nurses did not play a partisan role in the dispute, staying in the hospitals; however, there was both support and opposition to the Medicare system among their ranks (Robinson, 1967).

The Government of Saskatchewan (1951) further developed the recommendations in the earlier Weir report and endorsed moving nursing education away from hospitals and into centralized schools of nursing. Notably, the shifting emphasis to classroom
learning “coincided with the emergence of scientific medicine” and “although nurses...outnumbered the men...and could claim increasingly sophisticated and standardized training, they still remained subordinate to the medical men and their medical model” (Armstrong & Armstrong, 1996, p. 104). Until this time, nursing students had provided the majority of health care labour in hospitals. “Nursing students would no longer provide a free labour force, but would instead spend more time in formal education” (Armstrong, 1993a, p. 307). Given the continued nursing shortage, the report also recommended increasing student enrollment from 500 to 900 across the province.

At the same time, there was a lack of qualified nursing instructors to provide the required education as a number of smaller nursing schools across the province had closed (Bassendowski, 2005b). As a result of the limited number of nursing instructors, SRNA and the Canadian Medical Association (CMA) supported the development of the Centralized Teaching Program (CTP) between the University of Saskatchewan and Regina College that began in 1952 (Bassendowski, 2005b). Concerned with this loss of student labour, hospital administrators continued to support the apprenticeship style of education in hospitals and refused to support the new education system. Hospitals bargained with the provincial government for funding to substitute the worth of the student labour (Slater-Smith, 1987). Nursing schools needed to produce a nurse who was dedicated to maintaining the patriarchal ideology. “She will have the knowledge and the skills to apply at the bedside, but she will also give thought to the patient’s family, his community and the social and economic aspects of his illness” (Agnew, 1974, p. 125). Nurses’ self-sacrifice and subordination enabled the hospital to dictate their work.
Formative Years: 1960-2000

By the 1960s, an increasing number of women had entered the workforce with improved working conditions. This fact, combined with the women’s movement, pushed nurses to recognize standards of work and to challenge the traditional constraints placed on women in the workplace (Wuest, 1994). While nurses recognized the need for change, most of them remained silent and the profession remained notably absent from the women’s movement (Chinn & Wheeler, 1985). Many nurses opposed the women’s movement, believing that the spirituality and service of nursing were being lost. “Their beliefs did not require the professionalization of altruism, nor demand for autonomy either at the bedside or in control over the professionalization process” (Reverby, 1987, p. 9). Little change occurred for nurses in hospitals, as wages continued to be controlled without additional pay for long hours, and nurses continued to perform domestic chores outside the scope of their professional responsibilities (McPherson, 1996). Earlier, Nightingale had advocated for wages although she later conceded this point “for fear public opinion would turn against the nursing cause” (Slater-Smith, 1987, p. 6). Despite these general advancements for women, nursing continued to be situated in an ideology of domesticity and patriarchal dominance.

With increased health expenditures, the federal government moved the funding requirements to provincial health care budgets. In 1964 the New Democratic Party was defeated by the Liberal Party that ushered in many changes. In the fall of 1973, the NDP government closed the two remaining hospital schools in Regina and implemented a 2-year nursing program at the Wascana Institute of Applied Arts and Sciences (Slater-Smith, 1987). Hospitals were also re-organizing at this time with the South Saskatchewan
Hospital Centre (SSHC) taking responsibility for the Pasqua Hospital that the nuns had sold to the city the previous year. The province also purchased the Regina General Hospital and announced construction of the Plains Health Centre, a teaching hospital which opened in 1974 (Marchildon & O’Fee, 2007). At the same time, the health care system began to experience fiscal pressure and hospital nursing became the first target (McPherson, 1996).

Organized labour bodies for nurses were being established across Saskatchewan as prior to this “nurses by law could not form certified bargaining units” (McPherson, 1996, p. 251). The first collective bargaining unit, Staff Nursing Associations (SNA), was created as an avenue for nurses to express grievances through representatives to hospital administration. Initially, when the Trade Union Act was introduced by the provincial government in 1944, SRNA petitioned to have nurses excluded from the Act on the grounds that they were professionals; however, by 1964 it was acknowledged that change needed to take place and they approved the collective bargaining process (Slater-Smith, 1987). SRNA’s labour relations representatives negotiated collective agreements with hospitals in the province. Tensions grew between nurses and hospital administrators as nurses pressed for collective bargaining (McPherson, 1996). “As the rank-and-file nurses became more vocal through unions, the division between them and nursing leaders who aspired to professional status for nurses became deeper” (Melchior, 2004, p. 344). Until this time, nurses were discouraged from questioning their work conditions. While some nurses favoured the unions, many others believed that “improved wages and working conditions were viewed as selfish, impertinent, and demeaning...as society would pay them for what they are worth” (Slater-Smith, 1987, p. 4). In 1973, a monumental decision
by the Supreme Court ruled SRNA should not be negotiating because nurse managers were members and a conflict of interest therefore exited. This decision was considered a “landmark in Canadian labour law” (Slater-Smith, 1987, p. 24) that impacted nurses’ associations across Canada (Armstrong, 1993a). Finally, after much work, the Saskatchewan Union of Nurses (SUN), the largest union in the province at the time, was established to represent and negotiate on behalf of nurses employed in Saskatchewan hospitals.

Almost immediately following its inception, SUN began negotiations for increased wages and better working conditions (Slater-Smith, 1987). This resulted in job action and SUN’s first strike which lasted 24 hours. Subsequent strikes resulted in wage increases and improvements in work schedules such as having every third weekend off. The nurses’ strike of 1976, which lasted 10 days, became a political issue that dominated question period (Slater-Smith, 1987). By the early 1980s, nine out of ten nurses were women and three quarters of them were unionized (McIntyre & McDonald, 2010). SUN continued to grow, establishing a labour school and a bi-monthly newsletter (Slater-Smith, 1987). Improved pay and work conditions helped nurses change their views about unions. Nurses also realized that “the hospital system would not completely collapse” when their services were withdrawn (Slater-Smith, 1987, p. 57). Hours of work and benefits had improved to a certain level for nurses in hospitals.

By the 1980s women who had entered the work force in growing numbers over the past four decades accounted for 44% of the paid workforce (Leger-Anderson, 2006). The province had experienced economic growth up to this time; however, by 1981 a national recession was looming (Slater-Smith, 1987). Out-migration from the rural areas
resulted in reduced utilization of rural hospitals (James, 1999). A decrease in transfer payments from the federal government caused a reduction of public services as the provincial government experienced growing debt and deficit. In 1988, the Devine government established the Murray Commission to provide recommendations on reducing government expenditures, including those associated with health care (Marchildon & O’Fee, 2007). This resulted in health care restructuring, cost containment strategies, and extensive lay-offs, all of which contributed to an ambiguous work environment in hospitals and intensified workloads for nurses (Ceci & McIntyre, 2001).

Changes to the Trade Union Act in 1978 by the Conservative government also resulted in lost wages for nurses. SUN attempted to manage the layoffs (Slater-Smith, 1987). Many blamed nurses’ wage settlements as contributing to the rising hospital costs. With increased expenditures, hospitals changed the staffing of nurses. A number of full-time positions were decreased to part-time and casual positions; many were filled by ancillary workers (McIntyre & McDonald, 2010). The largest group employed in hospitals, mostly female nurses, was the target of patriarchal decisions, because hospitals are a large government expense most of which is associated with labour costs. “As nursing human resources are one of the primary budgetary items for hospitals, they are clearly targeted for cost-cutting measures in times of fiscal restraint” (Bourgeault, 2006, p. 270). Meanwhile, minimal effort had been made to decrease the number of physicians or curtail their fee schedules, leaving them in control of health-care expenditures (Magna, 1993).

Health care dominated the political arena as restructuring continued into the 1990s. Economic constraints led to radical changes within the health care system. “Representing
the largest single expense in the public health-care system, hospitals…were the first target of cuts” (Chappell & Penning, 2009, p. 171). Hospitals eliminated beds and merged units, departments and programs (Aiken, Clarke, & Sloane, 2002). Hospital mergers and bed closures left only the most acutely ill in hospitals. The public expressed concern about access to services, patient safety, and quality of care. Nurses raised concerns over job losses, understaffing, higher workloads, and increased levels of stress (Rankin & Campbell, 2006).

In 1992, the province’s newly elected NDP government embarked on further cost-cutting measures. Reduced hospital funding resulted in the closure of 52 rural hospitals; the only urban hospital closure in the province, the Plains Health Centre in Regina, occurred in 1998 (James, 1999). In the midst of these structural changes the challenges nurses faced in their workplaces were largely ignored (Backman, 2000; Rankin & Campbell, 2006). Some nurses were relocated to the Pasqua and General Hospitals, while other positions were eliminated. Other changes resulted in staff reductions and a further reorganization of nurses as the province moved to the regionalization of health boards and the creation of 30 health districts across Saskatchewan (James, 1999; Leger-Anderson, 2006). With fewer staff, nurses experienced increased workloads that further added to the declining work conditions. Nurses were rationalized in economic terms and considered expendable, being “laid off in large numbers, while those who retained their positions endured frustration and distress in difficult working conditions” (Ceci & McIntyre, 2001, p. 125). The changing labour market made hours of work and full-time jobs for nurses scarce, creating competition and rivalry for nursing positions.
Between 1995 and 1997, 10% of nursing graduates left to work in the United States. Major cutbacks to hospital budgets made jobs hard to come by and, in response to the decreasing need for nurses, enrolment was dramatically cut back in nursing schools (Romanow, 2002). Nurses not driven out by downsizing voluntarily left the profession because of increased workloads, job stress, forced overtime, stagnating pay, and personal burnout (Gordon, 2005). In 1997, SRNA briefed the government department responsible for hospitals, Saskatchewan Health, about an impending nursing shortage; in 1998 SUN asked the Saskatchewan Association of Health Organizations (SAHO), which bargains collectively on behalf of all regional health authority boards, to begin negotiations regarding the nursing shortage and they refused. On February 4, 1999, Regina Leader-Post reporter, Murray Mandryk wrote:

   It’s not only unbelievable, but unacceptable that those running the health district…could allow this to happen. But it’s equally unbelievable that Premier Roy Romanow and his Health Ministers, Atkinson and Judy Junor, former SUN President, could claim to have been caught off guard by a nursing shortage that Atkinson said wasn’t supposed to hit until 2011. (p. A11)

   Another nursing shortage had begun and the nurses who remained were forced to do overtime, cancel vacations, and work double shifts. The voice of the nurse had been irrelevant throughout the restructuring, and increasing frustrations with workloads and unsafe working conditions resulted in a history-making nurses’ strike. On April 7, 1999, 8,400 SUN members walked off the job (Powell, 2006) only to be legislated back to work 6 hours later by the New Democratic Party government. Nurses defied the legislation and remained off the job until issues of pay equity and patient safety were addressed (Powell, 2006). After 10 days, nurses returned to work. Wages increased to twice what had been offered and the government announced funding for 200 additional nursing positions.
Nurses became the target for issues in health care; their salary hikes and militant stance were seen as self-serving and lacking compassion (Rankin & Campbell, 2006).

At the same time, nursing education evolved to meet the CNA’s policy and SRNA's mandatory requirement that a university degree be the minimum qualification to practice nursing in the province by 2000 (Wotherspoon, 2008). Originally, the provincial government adamantly opposed this change and recommended a 3-year diploma as an option to meet the nursing shortage. Nurse leaders in education and SRNA refused to return to diploma education for nurses and, after much discussion, Health Minister, Pat Atkinson, rescinded the decision. However, in response to the government's opposition, the Nursing Education Program of Saskatchewan (NEPS), a partnership between SIAST and the University of Saskatchewan, agreed to offer an accelerated program providing students with the opportunity to graduate in 3 years.

**A New Century: Prevailing Problems Continue to Plague Contemporary Hospitals**

Across Canada, decades of restructuring have had profound effects on the health care system (McIntyre & McDonald, 2010). In Saskatchewan, another health reform in December 2001 resulted in the amalgamation of health districts into 12 regional health authorities. Locally, hospital services were reduced and consolidated to one or another hospital (Government of Saskatchewan, 2002). Shortened hospital stays and an aging patient population left hospitals with higher acuity patients and overcrowding which have resulted in an increasing workload for nurses (Rankin & Campbell, 2006). Nurses, unlike physicians, are usually unable to control their workload (Mitchell, 2003). Physicians, unlike nurses, are not required to collaborate about decisions regarding their patients.
“Cost, not quality of patient care, is typically the driving priority behind many healthcare decisions” (Mitchell, 2003, p. 220). The care of the patient is inherently part of the nurse’s role; however, “nurses’ recommendations about how to improve quality of patient care are not usually sought after, and when they are, recommended changes are not acted on by administrators” (Mitchell, 2003, p. 220). Situated in the hospital hierarchy, nurses remain largely unheard in health care delivery decisions. “Rather because, amidst the din of other apparently more significant voices and interests, these concerns of nurses have not been heard” (Ceci & McIntyre, 2001, p. 123). Nurses continue to be viewed as an extension of medical discourse intended to support physicians. “The marginal position of nurses is unquestionably related to the subordinate status of women and aspersions cast on the value of what is called ‘women’s work’” (Ceci & McIntyre, 2001, p. 128).

Nurses continue to work in environments dominated by the values of others (Peter, Macfarlane, & O’Brien-Pallas, 2004). Economic decisions have ruled as the pressure to fill vacant nursing positions, while reducing costs, has resulted in replacing nurses with Licensed Practical Nurses (LPN) and even unregulated health care workers in hospitals (Campbell, 2000). The mixed health care team has divided unions and professional organizations and created conflict in the work environment. The downsizing of hospitals has also led to the elimination of nursing management positions, namely head nurses, that has resulted in increased responsibilities for front-line nurses (Campbell, 2000). “The ongoing reality is that nursing represents a feminist ideology of caring, nurturing, holism and inclusion that is essentially devalued within a male-oriented social and political institutional structure” (Boychuk Duchscher & Cowin, 2006, p. 155).
Nurses have noticeably left the profession while the recruitment of nurses in some areas has become problematic (Rankin & Campbell, 2006). The conditions resulting from early restructuring have made nursing a less attractive profession (Zeytinoglu et al., 2006). Besides the adverse working conditions, an aging nursing workforce, fewer nursing applicants, and the international poaching and export of nurses have created a chronic nursing shortage (Mitchell, 2003). Earlier attempts by SRNA and SUN to make the government aware of the impending shortage were ignored. “Twenty years of recommendations for addressing the projected nursing shortage have generated little actual change in administrative/government policy and practice” (Mitchell, 2003, p. 220). Despite the evidence, hospitals assumed that “women (were) interested in self-denial, servitude and the expression of their natural qualities as women…the workplace still operates to some extent on that basis-expecting many nurses to work harder than ever for less and less” (Stuart, 1993, p. 22).

In 2007, after 16 years of a New Democratic Party government, the Saskatchewan Party was elected. Less than 1 year later, the SUN/government partnership, the first ever of its kind in Canada, was created to address the recruitment and retention of nurses in the province. Several months following the establishment of this partnership, the new government averted a strike and SUN negotiated one of the largest monetary settlements for Saskatchewan nurses (Saskatchewan nurses get 35% offer, 2008). To address the chronic nursing shortage in Saskatchewan, the government also increased nursing education seats; nevertheless, working conditions for nurses remained unchanged. “New managerial strategies designed to shorten patient hospital stays and provide more care on an out-patient basis have dramatically increased the pace of nursing” (Armstrong, 2006,
Overcrowding in hospitals has become a daily occurrence and hallway nursing, the norm. Hospitals have created policies to normalize the practice and nurses are forced to adjust their work accordingly. Although gains have been made, hospital priorities clearly dictate nurses’ work.

The global economic downturn in 2008 impacted Saskatchewan commodity prices resulting in reduced monies allocated to health care spending. At the same time, the government commissioned Tony Dagnone, former president of Saskatoon’s Royal University Hospital, to review the Saskatchewan health care system. In October 2009, the *Patient First Review* report was released; it detailed inefficiencies and areas for improvement (Dagnone, 2009). Simultaneously, Saskatchewan hospitals introduced lean practices as the provincial government believed these strategies would improve efficiency. By 2010, most nursing units adopted Releasing Time to Care™, a program which applies lean principles and is considered a “response to cost constraint measures …as nurses’ work is organized to maximize their efficiency” (Varcoe & Rodney, 2009, p. 128). While hospitals redefine themselves, nurses continue to work in a system embedded in paternalistic values that largely ignores them. “The acute-care setting continues to be dominated by Medicine, thereby reducing the autonomy and role fulfillment of bedside nursing” (Boychuk Duchscher & Cowan, 2006, p. 155). Nursing work environments remain oppressive as nurses are powerless, exploited, and marginalized because of the continued dominance of medical and business values.

**Conclusion**

From its inception, “nursing was historically organized with the expectation that its purpose was to care as a duty” (Chappell & Penning, 2009, p. 132). This archetypal
female vocation has experienced a history of socio-political and economic influences (McPherson, 1996). Since the early 1900s, social change has influenced nurses. “Many of the social and political gains made by women over the last hundred years have been the result of struggles to include women in the rights and privileges which men have instituted to serve their own interests” (Weedon, 1997, p. 2). Much of the profession has developed positively through the influence of the women’s movement and unions; however, paternalistic authority continues to dominate hospital ideology.

Traditionally, caring for the sick has been designated as women’s work. Early nurses acted as domestic servants, the good woman being silent is a good nurse to physicians and the hospital hierarchy. Later, nurses moved from private-duty nursing to hospital nursing, dedicated to the sick as well as the physician, training and participating within the hospital structure. Because of the demand for nurses, nurses organized professional associations and unions, bringing attention to work and pay conditions. Historically, strikes have highlighted nurses’ work and increased salaries, yet nurses remain subordinated by medical and hospital domination. Unlike physicians for whom changes are “not imposed on medicine but are negotiated” (Chappell & Penning, 2009, p. 123), nurses are directed by the priorities and agendas of hospitals.

The majority of nurses, mostly women, continue to work in the contemporary hospitals of today where they are bound by the medical profession and hospital altruism. Primarily, nurses still “remain responsible for implementing physicians’ orders” (Chappell & Penning, 2009, p. 216) and surrender to hospital agendas. A nurse’s gendered role has evolved from the social and historical construction of views of women. To some extent, nurses’ work has changed, influenced by an ever dynamic context;
unfortunately, the politics of gender, and social and economic discourses continue to rule nurses’ work in contemporary hospitals. “There must be sufficient critical awareness of the issues and operating ideologies to make resistance the norm rather than simply the maverick behaviour of an individual” (Varcoe & Rodney, 2009, p. 138). Thus, this research was driven by the passion to reveal the discourses and ideologies that influence nurses and their work in acute care.
CHAPTER 2: SITUATING THE LITERATURE

Abstracted Discourses About Nurses and Their Work Environment

Unlike a traditional literature review, institutional ethnography uses literature to frame what needs to be known, to explore what already exists, and to establish the researcher’s position (Campbell & Gregor, 2002). For this study, I reviewed the literature’s conceptualization of the nurse’s work environment in acute care to provide a better understanding of my problematic. A thorough search of the concepts resulted in a number of relevant articles. “A review of relevant literature is the basis for analysis and critique of what is already known about events of the kind that the researcher is exploring” (Campbell & Gregor, 2002, p. 50). This literature review identifies and critiques how abstracted concepts and dominant discourses about nurses and their work environment have been constructed in the literature. “Conceptions of social systems and social structure are theoretical constructs that can be assigned a determining role in human behavior without claiming an empirical reference” (Smith, 2005, p. 54). This review seeks to unpack the everyday taken-for-granted assumptions that have been constructed about nurses’ work and to gain an understanding about how nurses’ work is discussed in the literature.

There is an abundance of research dedicated to describing nurses’ work and work environment in the literature. Many authors conceptualize the context of acute care as fast-paced, chaotic, highly complex, rapidly changing, challenging, unhealthy, stressful and hectic (CIHI, 2006; Edward, 2005; Hamilton et al., 2010; Hodges, Keeley, & Grier, 2005, McAllister & McKinnon, 2009; Quality Worklife-Quality Healthcare Collaborative, 2007). These concepts contribute to the construction of nurses, their work,
and their workplace. The literature is replete with studies discussing the working conditions nurses face within this context (Aiken et al., 2002; Lambert & Lambert, 2001; McVicar, 2003; Yin & Yang, 2002; Zeytinoglu et al., 2006). Repeatedly, hospitals are vilified as problematic workplaces. “The workplace for nurses provides a multiplicity of sources of stress” (McVicar, 2003, p. 640). The literature contends that the nurse’s work environment is an adverse one that Jackson, Firtko, and Edenborough (2007) describe as “any negative, stressful, traumatic, or difficult situation or episode of hardship that is encountered in the occupational setting” (p. 3). Many authors point out that nurses’ work is physically and emotionally challenging, while maintaining that adversity is an inherent part of a nurse’s work environment (Ablett & Jones, 2007; Jackson et al., 2007). Some authors even predict what stressors trigger stress in nurses (Greenglass & Burke, 2001). Others have ranked nurses’ workplace issues: “workload might be rated from somewhat stressful to so crushingly high” (McGillis Hall & Kiesners, 2005, p. 2488). How are such conditions inherently constructed as part of nurses’ work? Given the strong evidence, one could simply assume that this is a normal part of the nurse’s work; however, all the studies must be considered together as the groundwork for constructing an understanding about nurses and their work.

Overall, the literature cites a number of problems inherent in hospitals including: the nursing shortage, restructuring, excessive and increasing workloads, increasing patient acuity, overcrowding and more recently, the aging workforce (Ablett & Jones, 2007; Edward, 2005; Gillespie, Chaboyer, & Wallis, 2009; Greenglass & Burke, 2001; Scholes, 2008a). The hospital’s problems are rationalized as causing nurses’ stress. “Workload as an issue is affected by acuity, absenteeism and understaffing…which in
turn affects stress levels” (McGillis Hall & Kiesners, 2005, p. 2488). The literature
discusses the nursing shortage as a re-occurring problem for hospitals and, “as working
conditions worsen, more nurses opt out of the profession, creating shortages on hospital
floors and resulting in even greater speedups, stress, safety worries and similar conditions
that drive additional nurses out of the industry” (Lafer, 2005, p. 31). Similarly, other
authors depict the causes of nurses’ stress as: “heavy workloads, long hours, low
professional status, difficulty in carrying out professional roles, and a variety of
workplace hazards” (Baumann et al., 2001, p. 1). Since nurses have no choice but to work
in these circumstances, they have simply become part of their work. McNeely (2005)
states, “this stress is an assumed cost of doing nursing work, and consequently, stress
may be interpreted as an individual’s problem to solve” (p. 294). Although articles and
research studies provide numerous examples, they lack in considering how nurses’ work
is constructed within this context.

“Nurses who work in hospitals must face the problems inherent in working in a
complex organization” (Benner & Wrubel, 1989, p. 366). The literature situates nurses in
the everyday quagmire of problems associated with acute care, while attempting to
explain their work. “Nurses cannot avoid encountering an increase in workplace
stressors” (Lambert & Lambert, 2008, p. 38). Within the hospital context, researchers
agree that these so called stressors, adversities, challenges, unfavourable conditions and
workplace hazards are part of nurses’ work, yet they neglect to discuss how they have
become part of nurses’ work (Baumann et al., 2001; McGrath et al., 2003; O’Brien-
Pallas, Hiroz, Cook, & Mildon, 2005). Within the literature, the concept of stress is
consistent in the discourse describing nurses’ work environments. “There is a growing
body of research about stress in nursing and there are some general indications of the stressful nature of the job” (McGrath et al., 2003, p. 555). Over and over again, the literature describes this as part of nurses’ work. “Nurses are exposed to a number of stressful and potentially distressing situations as a consequence of their daily work practice” (Mackintosh, 2007, p. 983). The stressors and work conditions are well known; however, what is less well known is how these have become normal, taken-for-granted conditions of nurses’ work. Clearly, a deeper understanding of the concepts and discourses explaining nurses’ work needs to be sought. “The resignation toward stress and the taken-for-granted assumption of individual responsibility and culpability may forestall serious scrutiny of nurses’ job stress that is rooted in their place of work and not in their heads (McNeely, 2005, p. 294).

Healy and MacKay (2000) concur that nurses will undoubtedly experience stress and adversity in their careers, including the known adversities that can be considered outside the nurse’s role, in acute care (Canadian Nurses Association [CNA], 2008). Yet, these concepts are all too common when authors discuss nurses’ work. “The occupation is plagued by a wide variety of stressors, such as demanding patient contacts, time pressure, and work overload” (Demerouti, Bakker, Nachreiner, & Schaufeli, 2000, p. 455). McNeely (2005) adds to this list: “sicker more demanding patients, technically complex care and leaner organizations” (p. 292). These factors are assumed to be a normal part of nurses’ everyday work and the hospital is frequently cited as a stressful environment, two persistent themes in the literature. “Nursing is, by its very nature, an occupation subject to a high degree of stress” (Hingley, 1984, p. 19.). Although stress isn’t in their job description, nurses must accept that their work is stressful.
Although the nursing literature repeatedly discusses the stressors and stress associated with the work of nurses in hospitals, it doesn’t explain how these concepts have become embedded in nurses’ work. Rather, it has been invisibly constructed as a part of what nurses will experience at work as “there is evidence to support the belief that nursing is stressful” (McGrath et al., 2003, p. 555). Years of research describe the obvious; however, few authors seek to understand how nurses’ work has been constructed as such. Given the dearth of research dedicated to this topic, one could accept the literature’s conceptualization and take for granted that nurses will experience something in their workplace. There is, however, a definite lack of literature about how this has come to be anticipated and normalized.

Several studies on stress in nursing attempt to measure and discuss the effects of stress on the nurse (Foxall, Zimmerman, Standley, & Bene, 1990; Healy & MacKay, 2000; Laschinger, Finegan, Shamian, & Almost, 2001). “One important consequence of nursing stress is the process of burnout, with its resulting affective and physiological symptomatology” (Hillhouse & Adler, 1997, p. 1781). Other authors assume that nurses’ burnout is related to the working conditions in acute care (Healy & McKay, 2000). The working conditions are also correlated to physical and mental job strain (Bourbonnais, Comeau, & Vézina, 1999; Laschinger et al., 2001). “Research has made it clear that problems with nurses’ work and work environments, including stress, heavy workloads, long hours, injury and poor relations with other professions can affect their physical and psychological health” (Baumann et al., 2001, executive summary, paragraph 5).

More recently, studies link working conditions to patient safety and quality of care (Rogers, Hwang, Scott, Aiken, & Dinges, 2004), implicitly making nurses somehow
responsible. Browne (2009) agrees that nurses “are being asked to deliver the very highest in quality care under systematic pressure to perform in an environment that increasingly rewards expediency and rapid-fire care” (p. 254). Research tends to focus on the hospital, patient outcomes, and nurses’ physical and mental health, yet few have explored the dominant discourses. While these abstractions frame part of the understanding of the actualities of nurses’ work, they do not reveal how that work is ideologically situated within the context of acute care.

Given the ongoing problems, some authors suggest simplistic strategies to remedy the infected hospital. Some offer solutions that put the responsibility on the nurse while negating the persistent problems. Education and encouragement are commonly suggested as remedies for the anxiety associated with stressful work (McGrath et al., 2003, p. 555). “One useful way to alleviate the cumulative effects of stress involves the use of staff development programs” (DiGiacomo & Adamson, 2001, p. 109). Other authors agree that given the issues, stress is simply part of the work environment and that nurses should be able to find an approach that reduces their stress and just come to work. “It is apparent ...that stress-reduction approaches should be implemented in nursing workplaces” (McGillis Hall & Kiesners, 2005, p. 2490).

Overwhelmingly, a number of articles characterize the work environment as physically and psychologically demanding; however, most of the authors are remiss in providing specific examples on how this occurs. “Nurses are experiencing frustration and stress that is impacting their work life, family and home life, as well as their personal health” (McGillis Hall & Kiesners, 2005, p. 2490). The literature contends that their working conditions affect nurses in many ways. There is increasing support from scholars
and policy makers to suggest that nurses’ health is at risk. “Nurses are at a particularly high risk for illness, emotional exhaustion and musculoskeletal injuries” (Health Canada, 2007, p. 15). The National Survey of the Work and Health of Nurses (CIHI, 2006) reports that nurses miss on average 14 days a year, compared to the average of 7 days per year for all employed individuals in Canada. Reasons for this include back problems, chronic pain, and depression that interfere with nurses’ ability to do their work or cause them to require time off (CIHI, 2006). “A demoralized worker is not a productive worker, and nurses have a sense they are not valued by the healthcare system for which they work so hard” (Baumann et al., 2001, executive summary, paragraph 5). Amazingly, the problems become evident only when there aren’t enough nurses to care for the patients or their absence is costing the system millions of dollars in replacement and overtime.

Jackson et al. (2007) add “nurses are under siege in the workplace, and are facing a whole range of problems and challenges as they go about their work” (p. 2). Similar findings are reported within the cultural context: “cross-cultural studies conducted in China, Japan, South Korea, Thailand, the USA (Hawaii), Australia, and New Zealand have suggested a number of similarities exist among nurses regarding workplace stressors and ways of coping with these stressors” (Lambert & Lambert, 2008, p. 40). The literature gives the impression that it is widely expected and anticipated, even universally, that nurses will experience stress in their work. Many of these work issues are nothing new; they linger from the past, persisting today. It is well known that nurses work in less-than-desirable conditions in hospitals. Some authors even suggest that nurses leave the profession because of workplace conditions: “Some nurses have tended to advocate for themselves by leaving an undesirable work environment” (McGillis Hall & Kiesners,
2005, p. 2483). Yet, nurses’ work issues become visible only when they reach beyond hospitals. As Clegg (2001) suggests “one of the motivations for this frenetic research into the subject is the political and economic consequence of stress-related illness” (p. 101).

Authors warn that urgent attention needs to be given to working conditions, as this will affect “not only the recruitment and retention of nurses, but also outcomes for patients, the system and families” (McGillis Hall & Kiesners, 2005, p. 2482). Nurses assume they will be rooted in unrelenting workplace issues. “Publications to date have directed limited attention to impact on the nurse and subsequently on the patient” (McGillis Hall & Kiesners, 2005, p. 2483).

The prevalent working conditions discourse constructs nurses as stressed, burned-out and depressed. “Because of the nature of their work, health care professionals are at especially high risk for experiencing the emotional exhaustion component of burnout” (Erickson & Grove, 2007, p. 2). Popular media constructs nurses as stressed, fatigued, overworked, prone to injury and in ill health, requiring time off from the overtime they worked to make their first million. The Regina Leader-Post adds to the representation of nurses working in the Regina Qu’Appelle Health Region (RQHR): “the RQHR says overtime was the biggest factor in its $6 million deficit, with sick time, high staff turnover, staff shortages and injury rates blamed” (Situation critical: Nurses overtime, 2010). Stress, illness and injury are all too commonly heard institutional or ruling discourses about nurses who work in hospitals (McCoy, 2006).

In the past decade the concepts of compassion, fatigue, and moral distress have also made their way into the discourse surrounding nurses working in acute care (Aycock & Boyle, 2009; Bush, 2009; Sabo, 2006). Ironically, given the press and the supporting
literature, it appears that nurses should anticipate derogatory labels and adverse working conditions in hospitals: “It is common when there are insufficient numbers of staff...and organizational policies and procedures that make it difficult, or even impossible, for nurses to meet the needs of patients and their families” (Corley, 2002, p. 636). Arguably, these working conditions go beyond the individual nurse and her health all the way to the effectiveness of the organization. After all, who is going to call in sick, grieve to the union, or address his or her member of the legislative assembly? Increasingly, researchers, governments, professional associations, and unions use this construction to move their agendas forward. Adverse hospital conditions are widely recognized yet surprisingly accepted as a normal factor in nurses’ everyday work.

**Coping 101: You Can Do It**

If resiliency doesn’t get a nurse through her work day then she might just consider coping. To add further vigour to this viewpoint, nurses are conceptualized as coping with their work in acute care (DiGiacomo & Adamson, 2001; Maslach, 2003; Maslach, Schaufeli, & Leiter, 2001). This concept is largely associated with work in the nursing literature. “Difficulties of working as a nurse and coping with the demands of nursing work have been frequently identified (Mackintosh, 2007, p. 983). It is presumed that coping is necessary for nurses to manage their stress and the stressors of the work environment. “Coping skills appear crucial to the mitigation of stress” (Mackintosh, 2007, p. 983). Nurses are constructed to be able cope within hospitals, regardless of the work, and still provide quality safe care. “It is obvious that nurses cannot change individually a large amount of stressors they encounter in their work life…nurses have to cope with those stressors in their work environment effectively” (Golbasi, Kelleci, &
Dogan, 2008, p. 1801). Coping is generally considered another way that nurses respond to or regulate stress and stressors in their workplace.

Some researchers even seek to understand how nurses “cope with their normal working practice, and to identify what factors…nurses consider to be important in enabling them to cope with their everyday work” (Mackintosh, 2007, p. 983). Nurses are also described in the literature as coping in either positive or negative ways thereby putting the responsibility and blame on them. Since nurses can’t change the structure, coping must be necessary to work in contemporary health care. “Health environments are notoriously bureaucratic and hierarchal…exposure to positive role models who share strategies on how to thrive …[is] an important inclusion in teaching and learning” (McAllister & McKinnon, 2009, p. 376). If she can’t cope with the work, then she can find a buddy so together they can be silent, happy women. Many authors assume that resiliency and coping with workplace conditions can be learned in order to be able to manage regardless of the work environment. “A programme …would involve teaching nurses to attempt to formulate solutions in coping with the difficulties they encounter at work, rather than avoiding problems and engaging in wishful thinking” (Payne, 2001, p. 402). Payne (2001) and Ceslowitz (1989) suggest stress-inoculation training to reduce occupational stress and, since “death and dying is an intrinsic part … and an unavoidable stressor”, nurses need to learn to cope with that, too (Payne, 2001, p. 404).

While acknowledging that the work environment is stressful, Ekedahl and Wengström (2006) state “nurses with access to several coping strategies can alternate between these strategies and can handle imbalances at work” (p. 137). Numerous approaches are offered to nurses in acute care such that “interventions can be designed to
provide direct support for nurses dealing with real-life issues in the workplace” (McGillis Hall & Kiesners, 2005, p. 2490). Chang et al. (2006) postulate “that nurses use various ways of coping with work-related stress but that the use of avoidance coping for nurses is generally detrimental to their health” (p. 31). The literature implies that nurses must have different ways of coping, or risk increasing their stress or negatively impacting their health. “Generally, it is believed that nurses with good problem solving skills” can cope with stressors of work; however, “the most intrinsically satisfied nurses, who are vigilantly attempting to solve the problems in their hospital, may find the attempt to cope…amplifies their stress” (Tyson, Pongruengphant, & Aggarwal, 2002, p. 459).

Nurses are urged to cope or face the risk of burnout and becoming unhealthy. “When stress-coping skills are not adequate, burnout may occur” (DiGiacomo & Adamson, 2001, p. 106).

Others describe varied individual strategies that nurses use to cope with work stress, including relaxation, having hobbies and outside interests, and practicing self-control (Chang et al., 2006; Edwards & Burnard, 2003). McGrath et al. (2003) report the single most important finding in their study is “that a coping mechanism specific to nursing may be that nurses unconsciously reduce stress in their job by setting nursing objectives as physical objectives in their job” (p. 563). This recurrent theme suggests that nurses either cope in positive or negative ways thereby once again putting the responsibility and blame on the nurse. It seems to be assumed that coping in the workplace involves resilience, which can be developed through support and education. The nursing literature concludes that although difficult working conditions are part of the
nurse’s workplace, it is assumed that individual coping mechanisms will mitigate the effects.

Establishing a healing, healthy environment is also promoted as an approach to stress and burnout associated with nurses’ work (Brown, 2006). In the past decade, healthy workplace research is prolific not only in the academic literature but is also supported by unions, government and professional associations (Health Canada, 2002; SRNA, 2008; SUN, 2009). If hospitals redefine working conditions as unhealthy, and name the causes of injuries and illness for nurses, perhaps there would be potential for improvement.

The Resilient Nurse: Hospital Super Heroes

Other concepts evident in the literature that add to the discourse include resiliency and the resilient nurse. Numerous researchers have studied the concept of resiliency; however, it is considered relatively new in the nursing literature. “It appears that resilience research among the many clinical streams of nursing is either yet to be realized or still in its infancy” (Gillespie, Chaboyer, & Wallis, 2007, p. 132). The majority of authors within the nursing literature define resiliency as the ability to rebound, to cope successfully, or to adjust to adversity and recover (Atkinson, Martin, & Rankin, 2009; Edward, 2005; Edward & Herceleskyj, 2007; Gillespie et al., 2007; Hodges et al., 2008; Jackson et al., 2007; McAllister & McKinnon, 2009; Tusaie & Dyer, 2004).

Resilience is glorified as a new way to survive work in the hospital. Some scholars assume that resiliency will enable nurses to survive and thrive, regardless of their work and work environment. Several authors even believe that resilience is necessary, essential, vital, and a valued quality for nurses to possess in their everyday
work (Edward, 2005; Hodges et al., 2005; Tusaie & Dyer, 2004). “Nurses bear witness to tragedy, suffering and human distress as part of their daily working lives, and because of the stressors associated with assisting others to overcome adversity” (Jackson et al., 2007, p. 4) they require resilience to cope. Resilience is repeatedly suggested as a way of coping with the work environment. “When working in a...stressful environment…resilience as a coping strategy may permit people to develop confidence in effectively dealing with changes, reframing negative experiences into positive” (Edward, 2005, p. 147). Some authors share their success stories and tout resiliency as a survival tool for nurses (Giordano, 1997) as well as an antidote for burnout (Edward & Hercelandskyj, 2007). Scholes (2008b) states, “resilience …is one strategy proposed…to reduce the risk of burnout and indeed take those who exhibit symptoms of burnout and facilitate their professional recovery” (p. 283). Another author states that resiliency is needed “particularly amidst the current nursing shortage” (Tusaie & Dyer, 2004, p. 3).

Regardless of the work environment, several authors assert that once resiliency is learned, nurses will be better able to work with adversity (Edward & Warelow, 2005; Hodges et al., 2005; Jackson et al., 2007; Warelow & Edward, 2007). Why is it assumed that a resilient nurse can work in a patriarchal hierarchy, safely caring for increasingly acute patients in the hallway? More importantly, authors overlook the connection between how dominant ideologies and discourses construct and situate nurses in acute care. Nurses possess “patterns of coping with job demands that reflect overcommitment to their work” (McGillis Hall & Kiesners, 2005, p. 2490). Resilience is not just another word for coping. Yet this description of extreme effort to overcome obstacles has also
become a taken-for-granted expectation of what nurses will do as a normal part of their work.

**The Nurse’s Problem**

Most notably in the literature, nurses are assumed to be the ones who need to change, not the work nor the hospital: “the environment in which health care is delivered is unlikely to change. This means that practitioners need to change their expectations or develop greater resilience with which to accommodate the demands that are made of them” (Scholes, 2008b, p. 283). As well, the National Survey of the Work and Health of Nurses (CIHI, 2006) states, “to meet the physical and emotional needs of patients and their patients’ families, nurses must be compassionate, skilled and resilient” (p. xix). Several authors suggest that nurses must be physically and mentally healthy to do their work. Because stress is a daily occurrence, nurses would benefit from stress reduction since “stress jeopardizes the professional’s ability to provide high quality care to patients” (Mann & Cowburn, 2005, p. 156).

Nurses have been described as stressed, burned out, coping, or resilient in the face of their adverse working conditions. The literature identifies the results of stress and stressors in acute care as nurses’ sickness and absenteeism, decreased quality and quantity of care, and recruitment and retention issues (McVicar, 2003). Interestingly, rewards are even suggested as the missing link in understanding nurses’ work. “These work environment factors demonstrate a high effort workplace with little or no evidence of reward conditions in place for nurses” (McGillis Hall & Kiesners, 2005, p. 2489). Thus, given the conditions of today’s workplace, the contemporary nurse is situated in the literature as either sick, stressed and burned out, or physically and psychologically
healthy, resilient, and able to cope with her work without any rewards. Perhaps she should pump weights and see her psychiatrist.

While the authors acknowledge challenging issues in the workplace, this message prevails: Nurses can adapt to their work environment. It is assumed that nurses can develop skills and behaviours - whether they be resiliency or coping or physical or mental health techniques - to sustain themselves in the environment. Interestingly, researchers provide many strategies to mitigate difficult work conditions; however, the effects of these are not apparent in the literature. While the strategies are basic and optimistic, they often point to the individual nurse. A self-sacrificing ideology continues to resonate in much of contemporary nursing research. Given the known embedded patriarchal history, issues of power and gender are surprisingly lacking in the literature on the nurse’s work environment. “The gendered nature of the workforce and the systemic hierarchies…are an integral part of nurses’ work experiences” (McGibbon, Peter, & Gallop, 2010, p. 1354). Yet, much of the literature ignores the historical influence and gender context. While a majority of researchers situate such concepts as part of nurses’ work, they are remiss in explaining how this has become part of that work.

Granted, significant work has been devoted to studying nurses’ work albeit mostly quantitative studies using survey methods (CIHI, 2006; Health Canada, 2007) that objectify nurses and silence their voices. “Current research often separates nurse reports from objective characteristics of the setting” (McNeely, 2005, p. 296). While the surveys report numerical data, historical influences and specific social relations are not considered in studying the nurse’s work environment. The research is largely situated within a positivistic reductionist approach in the nursing literature (Clegg, 2001).
Research provides evidence that the work of nurses in hospitals is characterized by considerable job stress and burnout (Aiken et al., 2002). Essentially, nurses can be counted and considered as data to validate the idea that they are stressed and their work is inherently stressful. Although much of the research provides statistics, theories, and definitions, the majority of studies do not discuss intersecting influences.

Given the literature’s construction, researchers give the impression that they lack an understanding of how the dominant discourses construct nurses and their work. “The emphasis on pervasive ideological structure has also had the effect of denying nurses subjectivity, for in accounts based on power and pervasiveness of structure, the voices of nurses have rarely been heard” (Wicks, 1995, p. 125). Few authors discuss the social processes and the ideologies which are embedded in nurses’ work. The dominant ideology of individual responsibility and blame continues to prevail in nurses’ work discourse. Authors negate the nurse as an active social agent and represent her as a passive subject. “Through its use, burnout victims can be fitted into socially acceptable therapeutic categories, and organizationally sanctioned methods of handling workers’ problems can be introduced” (Campbell, 1994, p. 606). In their best intentions, researchers focus on strategies to ‘fix’ nurses instead of addressing the conditions in the hospital. If researchers subscribe to stress-reducing strategies in the nurses’ workplace, then stress and burnout are legitimized and reduced to the attributes of the nurse who ultimately bears the blame. “Nurses are reporting higher stress levels, high job insecurity levels and poor morale” (Greenglass, Burke, & Fiksenbaum, 2001, p. 211). Acute care exists within objectified knowledge, while the concepts provide particular discursive meanings and discourses about nurses’ work. This implicit acceptance about the
construction of nurses’ work is all too common in the literature. Unknowingly, this provides the impetus for prescribing methods to cope and become resilient rather than looking deeper at the situation.

The importance of studying nurses’ work cannot be understated, yet little research has directly explored the social context of their work environment. The literature presents a way of speaking about nurses’ work as problematic. This discourse pervades the majority of articles and research studies on acute care. “The stress, danger, exhaustion, and frustration that have become built into the normal daily routine of hospital nurses constitute the single biggest factor driving nurses out of the industry” (Lafer, 2005, p. 36). Nurses are forced to participate in a challenging system and pretend that they are not influenced by the work environment. Why do nurses, primarily women, just take for granted that this is how work is going to be? “The objectified forms, the rational procedures, and the abstracted conceptual organization create an appearance of neutrality and impersonality that conceals class, gender, and racial subtexts” (Smith, 1990a, p. 65).

Strangely, gender is notably silent in much of the research. McAllister and McKinnon (2009) frame gender and the patriarchal workplace in their discussion as a reason for teaching resilience. Armstrong (2006) notes that nurses, most of whom are women and over age 40, do not fit the predominant image which “still assumes that young, fit women are doing the bedside care [and] because nurses are women, we have not understood the work as physically demanding in the same way as we see much of men’s labour as physically demanding” (p. 292). Similarly, Romanow’s (2002) highly publicized Report of the Royal Commission on the Future of Health Care in Canada highlights illness and injury rates yet “considers this an issue without mentioning that
more than 9 out of 10 registered nurses are women” (Armstrong, 2006, p. 292).

Regardless of their age, nurses are assumed to be the hospital’s Trojan work horses. To no surprise, nursing is now touted as the most dangerous occupation in the literature (CIHI, 2002). Yet, the literature is remiss in explaining how women as nurses work within a patriarchal ideology influenced by history and socio-political powers in their workplace.

Few authors have discussed history’s link to contemporary health care as boldly as have Boychuk Duchscher and Cowin (2006) who state “problems uncovered 40 years ago continue despite enhancement of healthcare delivery methods and technologies …throughout the acute-care setting” (p. 152). While contemporary hospitals may look different, clearly, inside little has changed since the early days; hospital issues have just become part of nurses’ work. The fact is that the hospital system continues to be patriarchal in nature even though more and more doctors are women. “Sheer force of number does not ensure equal distribution of power as nursing can testify” (Tosh, 2007, p. 75). Evidence of the patriarchal hierarchy in hospitals is mentioned in some of the literature; however, authors, by and large, do not readily acknowledge or critically explore the nurse’s work environment. Conversely, McPherson (1996) states, “The strength of occupational relationships…has been tested over the years… revealing the resiliency of paternalist gender relations and of maternalist relations among nurses, but also the fissures that were beginning to emerge” (p. 243). Obviously, this has many authors’ attention; knowing that a burned-out nurse works in a chaotic and stressful environment but really should be able to cope and become resilient would make for an interesting read.
By and large, gender and power issues, as well as nurses’ voices, are notably silent in the majority of the nursing literature. “Nurses are marginal by virtue of their work, as well as by gender” so much of nurses’ work is “unspoken, unrecognized, and unappreciated by the dominant groups, and therefore, by society at large” (Miller, 1991, p. 49). While the nurse and her work environment have been widely studied, and evidence supports the embedded patriarchal ideology that dominates nurses’ work, issues of power, gender and oppression are clearly missing from the nursing literature. “Questions about …gender and institutional hierarchies are seldom linked to nurses’ experiences of stress” (McGibbon, 2004, p. 11). To my surprise, most of the authors fail to discuss the historical, social, and political forces on nurses’ work even though nurses and the environment in which they work are profoundly influenced by the intersections of multiple powers. This review uncovered many of the taken-for-granted concepts, discourses, and assumptions embedded within the literature.

Conclusion

The background literature provides an understanding of how nurses’ work is conceptualized within the hospital context. Sadly, these concepts have become part of the nurses’ workplace discourse. For years, authors have contributed to the growing body of literature describing nurses’ work; however, few give attention to the known ideologies that continue to rule nurses’ work in acute care. Their work in the hospital is constructed through the literature as stressful and problematic, yet inherently a part of what they do. These implicit assumptions construct nurses as stressed, resilient, or suffering from burnout. The centrality of oppression and power has led to nurses clearly situated within an embedded patriarchy. The existing body of knowledge on nurses’ work found in the
nursing literature provides a greater understanding of the aforementioned concepts and assumptions in these areas. This literature review seeks to expose the prevalent discourses and the intersection of multiple influences that concern nurses and their work environment. Conceptualizing the interplay of socio-political influences requires a specific methodology. The next chapter, therefore, will discuss how nurses’ work is understood through a poststructuralist stance, guided by the social ontology of the feminist-inspired method of institutional ethnography.
CHAPTER 3: THE RESEARCH STRATEGY

Two Perspectives to Understanding Nurses’ Work

This research was guided by the social ontology of institutional ethnography (IE) and a feminist poststructuralist perspective. Employing this approach has the potential to reveal the underlying influences and power structures through which hospitals coordinate nurses’ everyday/everynight work. Institutional ethnography’s ontology of the social sees people as real, existing and found in the activities of individuals’ everyday/night lives. This assists in understanding of how nurses’ work is organized by unseen power relations in acute care. “It discovers the social rather than theorizing about it, beginning with the actual people, their doings and how their doings are coordinated” (Given, 2008, p. 433).

Since prevailing ideologies and discourses unknowingly influence women as nurses, their work, and their work environment, a feminist poststructuralist perspective of power and gender sought to understand their constructions. Institutional ethnography makes visible the social organization and the ways of thinking; in this research, nurses and their work in acute care. It exposes the taken-for-granted social and ruling relations that unknowingly exist and extend beyond nurses’ work as part of the institutional discourse. Together, institutional ethnography and a feminist poststructuralist perspective allow for the exploration of the “relationship between language, subjectivity, and social organization and power” (Weedon, 1997, p. 12) and in this study are used “to understand existing power relations and to identify areas and strategies for change” (p. 40). “Using a feminist poststructural lens, we can begin to see how knowledge produced under the auspices of positivism, interpretivism, and critical social science have been confined and confirmed by their own discourses” (Barrett, 2005, p. 89). While each approach is unique
“institutional ethnography can be situated as one tributary in the flood of poststructuralist scholarship” (DeVault, 1999, p. 49). Thus, both assist in understanding the realities of acute care nurses’ work which are socially constructed and influenced by the social, economic and political processes that unknowingly rule nurses’ practice.

**Ontology of the Social**

Because the aim of this research is to discover the relations that organize nurses’ work in acute care, it was guided by institutional ethnography’s ontology of the social. IE seeks to provide an understanding of how it happens. “The notion of the social organization better reflects the core ontological focus on coordination, the organizing, routine processes in which people are active, and the actualities where their experience takes shape” (McCoy, 2008). In maintaining a social ontology, my focus was on how nurses work and how their doing is coordinated. “The discursive practices in which activities organize and are organized can be observed as on-going social actions, especially available as textually mediated practices” (Schick, 1998, p. 14).

**Epistemological Relevance**

“The emphasis on connectedness is key to understanding the institutional ethnographic ontology and epistemology, which combines a materialist foundation with a recognition of multiple views” (Smith cited in DeVault, 1999, p. 30). Epistemologically, IE combines several ideas including ethnomethodology’s attention to people and how social order is produced by people in their everyday activities (Quinlan, 2009). Unlike ethnomethodology, however, IE does not objectify people in their everyday world (Campbell, 1998). Although institutional ethnography includes Foucault’s interest of
power, it is also about studying the structures of power that pervade people’s experiences, beginning in their location of living and doing their everyday lives (DeVault, 1999; Smith, 2006). Institutional ethnography also views power as being pervasively structured through a complexity of organized practices or, as Dorothy Smith calls them, the ruling relations (Smith, 1987, 1999). In this research the social organization of power is explored through nurses’ and their work in hospitals.

IE also includes Marxist thought by addressing the economic and social processes to understand the everyday “practices of domination and subordination that are specific to contemporary times and not to Marx’s” (Smith cited in Campbell & Gregor, 2002, p. 39) with concept of ruling originating from Marx. Smith’s theory and method also draws on the phenomenology of everyday experiences and how they emerge (Campbell, 1998; Townsend, 1998). Originally influenced by the feminist movement, Smith began institutional ethnography solely as a feminist method; however, it may be employed to examine unequal relations across social positions. Thus, institutional ethnography provides a research process that investigates the social forms of knowledge, coordination, and control that shape nurses’ work in acute care (McCoy, 2008).

**Poststructuralist Feminist Perspective**

As researcher, I am interested in understanding how women and their experiences are oppressed or marginalized (Smith, 1977; Weedon, 1997). To further understand how gender and power are positioned in constructing the discourses of nurses and their work, a poststructuralist feminist stance provides an additional perspective in this research (Francis, 2000). “We need to understand why women tolerate social relations which
subordinate their interests to those of men and the mechanisms whereby women and men
decide particular discursive positions as representative of their interests (Weedon, 1997,
p. 12).

Feminist research produces knowledge for women rather than about women
(DeVault, 1999). “The shared perspective that society is patriarchal and oppresses
women” (Weedon, 1997, p. 81) is a key assumption in this study. This knowledge,
emerging from a sociohistorical context, has dominated nurses and their work.
Poststructuralism has been successfully applied “to educational research in order to shed
new light upon the ways in which discourses” are acted out and are “useful for critiquing
current discourses and practices, but not for reconstructing new ones” (Francis, 2000,
p. 25). Nurses, the majority being women who work in hospitals, are connected to
discourses of power and social control. “As long as the relationship between nursing and
feminism remains invisible, the gender problems in nursing that are systemic to a
woman’s occupation in a male-dominated society will continue” (Kane & Thomas, 2000,
p. 17).

Although contemporary hospitals have advanced, somewhat, an ideological
paternalism continues to be embedded within the culture of acute-care environments
(Stuart, 1993). Nursing work environments remain oppressive as nurses continue to feel
powerless, exploited, and marginalized because of the continued dominance of medical
and business values (Cowin & Duchscher, 2006). “Feminist research is overt in its value
position of relieving women’s oppression” (Sigsworth, 1995, p. 898). Underlying
mechanisms of oppression reside in “systems of interrelated barriers and forces that
reduce, immobilize, and mold people who belong to a certain group in ways that
[reinforce] their subordination” (Kendall, 1992, p. 4). Using this combined approach for this research allows me to explore the conditions “whereby oppressions can be explored and understood” (Campbell & Gregor, 2002, p. 52). What will be explored is how nurses’ work in acute care is socially organized by embedded ideologies and moving institutional discourses. “Feminist researchers can use these experiences to explore and grasp the issues they are studying, and the researcher’s personal understanding of the issues can be a great advantage” (Hesse-Biber, 2007, p. 341).

**Nurses’ Standpoint**

This study starts from the standpoint of women, because the majority of nurses are women working in acute care (CIHI, 2008). From a feminist starting point, dominant discourses and practices that rule nurses’ work can be revealed. “Feminist standpoint theories privilege the everyday lives of women and others who traditionally have been invisible within the scientific and social scientific analyses” (Naples, 1999, p. 30). Additionally, Smith’s method of inquiry provides an approach that will “make gender visible in social phenomena, asking if, how, and why social processes…differ systematically in women and men” (Smith, 2005, p. x). In this study, women, working as nurses in hospitals, are assumed to be socially organized by several unknown forces, such as the patriarchal ideology and the various institutional discourses within the hospital. “The argument is not that women know better by virtue of occupying these positions, but that the work accomplished there must be part of any adequate account of social organization” (DeVault, 1999, p. 39). Smith’s (1987) method of inquiry views women as a social group who have separate experiences “as a result of the gendered distribution of labour” (Phillips & Jørgensen, 2002, p. 191). Thus, this research approach blends
institutional ethnography’s orientation to the social with the feminist poststructuralist perspective that provides an understanding of power and gender.

**The Ruling of Power and Knowledge: Discourses and Embedded Ideologies**

The actualities of class, gender, and race are dispersed over a range of sites within the institutions of ruling. Though not every instance conceals specific gender and class issues, investigating the actual social organization of knowledge brings the social relations organizing power into the light. If we don’t examine and explicate the boundaries set by the textual realities of the relations of ruling, their invisible determinations will continue to confine us. (Smith, 1990a, p. 65)

Smith (2005) believes that certain forms of knowing are the basis for ruling people’s everyday experiences. How knowledge is produced is important in understanding the social organization of ruling and social relations and “investigating the actual social organization of knowledge brings the social relations organizing power into light” (Smith, 1990a, p. 65). Social relations “refer to the processes by which people’s lives are shaped to conform to dominant ideologies” (O’Neill, 1998, p. 132; Smith, 1987). Unknowingly, nurses participate in the ideologies and discourses that are “formulated in concepts and theories” (Smith, 2004, p. 451) and that “treats the original actualities as expressions or effects of the concept or theory” (p. 453). One example in this research is the discourse of *stressed* nurses working in the *adverse* conditions of acute care. Nurses are embedded in “relations of ruling,” which can be described as “a complex of organized practices…as well as the discourses and texts that interpenetrate the multiple sites of power” (Smith, 1987, p. 3).

Nurses’ work is ruled by the politics of gender and the social and economic forces in contemporary hospitals. These ruling practices are a “sophisticated form of power” (Rankin & Campbell, 2006, p. 19) that support governments, managers, and physicians,
but not nurses. “Institutional ethnography shows how micro, everyday experiences are interconnected with macro, systemic processes in ways that routinely perpetuate inequalities in power” (Townsend, 1996, p. 181). Smith describes *ruling relations* as forces that organize and coordinate people’s everyday doings with those of others, most of which we are unaware (Smith, 1990a). Publicly, text-mediated discourses circulate and contribute to the ruling of nurses in hospitals (Smith, 1999). “Being ruled means that while actual people’s own participation remains integral to all forms of organization, their actions are being regulated, and their individual will and judgement are systematically superseded” (Rankin & Campbell, 2006, p. 17).

Smith (1999) further describes ruling relations as part of an historical trajectory in creating their development. “Historical development generates specific social relations; social relations are expressed in categories; the categories are the forms of thought in which the social relations come to the consciousness” (Smith, 2004, p. 457). Many unseen and historically embedded relations shape and organize the work of nurses. For example, nursing as women’s work and the physician’s handmaiden. These relations “vary over time…affecting how these events are experienced, defined, regulated and valued” (Ramazanoğlu & Holland, 2002, p. 99). Essentially, this is important in “tracing back its roots in the patriarchal social structure …as a critical ‘way of knowing’ the contradictions and the oppressive relations” (McKendy, 1992, p. 63). Nurses’ work is ruled by, but not limited to, the hospital hierarchy, external relations, and a patriarchal ideology that relies on selflessness and gender. “Women as nurses are exploited under ideologies that equate nursing with mothering and view the hospital ward as simply an extension of the domestic sphere of labour” (Wall, 2007, p. 39). The concept of ruling
combines power, organization, direction, and regulation as more pervasively structured in the social (Smith, 1990a). Ruling relations are embedded in institutions as a means of control that makes power less visible to those being controlled. Relations of ruling can also be considered as influences that are taken for granted to organize and coordinate work (Smith, 1990b, 2005).

Nurses, the majority of whom are women who work in hospitals, are connected to discourses of power and social control. “Poststructuralism can also indicate the types of discourse from which particular feminist questions come, and locate them both socially and institutionally” (Weedon, 1997, p. 20). Consistent with institutional ethnography’s view that discourse is an active part of social relations, this study exposes such discourses; however, “the ways in which discourses constitute the minds and bodies of individuals is always part of a wider network of power relations, often with institutional bases” (Weedon, 1997, p. 105).

Discourse and ideology are socially organized and coordinate the intersection of powers with other relations of ruling in professional organizations (Smith, 1987, 2005). In acute care, discourse and ideology invisibly rule nurses and their work. “The appearance of this hierarchy as natural and appropriate gives it a taken-for-granted quality that is very seldom questioned” (Wall, 2007, p. 38). Ruling discourses of power and control pervade and coordinate the activities of nurses across contemporary acute care. Unknowingly, these discourses are woven into nurses’ work and ultimately influence both the nurses and their work. The discourse is enacted through the conceptualization of acute care as chaotic, stressful, and adverse, and the construction of nurses as fatigued, stressed, and burned-out.
Hall (2006) describes ideologies as “active in our society and which provide us with the means of ‘making sense’ of social relations and our place in them” (p. 397). This is evident in discourses that routinely expect nurses to cope and become resilient to their working conditions. “Ideologies therefore work by the transformation of discourses…and…how we ‘see’ ourselves and our social relations matters, because it enters into and informs our actions and practices.” (Hall, 2006, p. 397). Ideology is the social organization of experiences and is considered a method of organizing the material world which, in this study, is the acute-care environment (Smith, 1987). Ideology can also be characterized as “those ideas and images through which the class that rules the society by virtue of its domination of the means of production, orders, organizes, and sanctions the social relations that sustain its domination” (Smith, 1987, p. 55).

Unknowingly, nurses are embedded in conditions which result in ideological practices within their work in acute care. These include, but are not limited to, the conditions such as the nursing shortage and overcrowding in acute care. According to Smith (1990a) “ideological practices” are “methods of creating accounts of the world that treat it selectively in terms of a predetermined conceptual framework” (p. 93). Smith further discusses ideological practices or procedures as “the methods of reasoning that effect that concealment” (p. 37). This research brings together nurses’ everyday work experiences “with a matching exploration of how” they are “framed through discourse” (Campbell & Gregor, 2002, p. 44). Nurses continue to work in a system that goes beyond nursing work, participating every day/night in a nursing shortage that has become chronic, reflected in the lack of hospitals beds and an embedded patriarchal ideology, all of which are considered part of the nurse’s typical shift. “Ideological practices ensure that
the determinations of our everyday, experienced world remain mysterious by preventing us from making them problems for inquiry” (Smith, 1987). Nurses’ work in acute care operates through particular types of ideological practices. For example, overcapacity of patients results in hallway nursing. “Ideological organization creates a disjuncture between the world as it is known within the relations of ruling and the lived and experienced actualities” (Smith, 1990a, p. 96).

Nurses are unknowingly organized to participate in these discourses and ideologies. This means recognizing that the rulings directing nurses’ work contribute to identifying their intersecting points. “Discourse and ideology can be investigated as actual social relations ongoingly organized in and by the activities of actual people” (Smith, 1990b, p. 160). Through these ideological practices, ruling takes place and is accomplished. Ultimately, these practices coordinate and organize nurses’ work within the institutional order of acute care. Thus IE provides a way “of looking out beyond the everyday to discover how it came to happen as it does” (Smith, 2006, p. 3). This method of inquiry makes visible how nurses’ work in acute care is “connected into the extended social relations of ruling” (Smith, 2005, p. 29). The explication of social relations and how these relations come to govern the nurses involved is what makes institutional ethnography different from most qualitative methods (Walby, 2007) and particularly well suited to this research.

IE’s method of inquiry reveals how the practices, previously outlined, organize and rule nurses’ work. This, along with a feminist poststructuralist perspective, can “critique...a patriarchal healthcare system and the claims that are revealed in discourses that are sites of inequality and political struggle” (LeBlanc, 1997, p. 258). This study
makes visible “forms of knowledge in which people as subjects disappear and in which their perspectives on their own experiences are transposed and subdued by the magisterial forms of objectifying discourse” (Smith, 1990a p. 4).

While institutional ethnographers are interested in “studying social settings and interaction in everyday life… they are interested in the particular conditions under which experiences arise and are lived by someone” (Campbell & Gregor, 2002, p. 59). Thus combined, a poststructuralist perspective attempts to “reflect on expressions of power” while not ignoring how “the social and political implications may replicate the current power structure” (LeBlanc, 1997, p. 260). Similarly, institutional ethnography and feminist poststructuralism do not objectify people but preserve their presence as participants. “The feminist task is to resist…identifying individuals as ‘other’ than, and to resist definitions that identify individuals in relation to the dominant culture” (LeBlanc, 1997, p. 261). Both approaches reject scientific positivism and assert subjectivism, power, and discourse as keys to understanding how things happen (Smith, 2005; Weedon, 1997). This assists in connecting the aspects of the institutional process that are relevant to the issues of concern and appear in how nurses talk about what is going on in their work. The combination of approaches in this study serves to explore how the patriarchy operates as a ruling relation and how they unknowingly participate in being ruled by discourses and ideologies.

**Data Gathering**

“Institutional ethnographies can be based on various types of data, and a single investigation often draws material from more than one source” (DeVault, 1999, p. 87). Smith (1987) discusses integrating three forms of data collection to describe work
processes: (a) participant observation of the work of a chosen segment of everyday life, (b) interviews to clarify, and (c) follow-up interviews to see how work processes are described, categorized, accounted for, evaluated, and/or otherwise socially organized. In this institutional ethnography study, I have used historical research, the literature, participant observation, field notes, interviews, and my reflections to understand how nurses’ work experiences are organized by processes that extend outside their everyday/night work.

What is important is that the research has a clear starting place in some setting where people are active from which the investigation can begin tracing out translocal relations of coordination and control, with a focus on the text mediated practices of knowledge that organize those relations. (McCoy, 2008, p. 704)

This research started with a desire to understand how nurses continue to work in the conditions of acute care. As discussed in the previous chapter, the nurse’s work environment has become synonymous with stressful conditions and nurses are categorized as burned-out and resilient, to name only two descriptors. However, rather than starting with concepts, I sought to explore how nurses and their work are constructed and organized in acute care.

**History**

Feminist poststructuralist perspectives (Weedon, 1997) and Smith (1987) view women as a social group who have separate experiences “as a result of the gendered distribution of labour” (Phillips & Jørgensen, 2002, p. 191). Starting with this assumption, dominant discourses and practices that rule nurses and their work in acute care can be explored. Because IE emphasizes the social, material, and historical locations, this study incorporated the history of nurses in acute care into ideologies that prevail to
rule their work. “As long as the relationship between nursing and feminism remains invisible, the gender problems in nursing that are systemic to a woman’s occupation in a male-dominated society will continue” (Kane & Thomas, 2000, p. 17). IE “situates processes and activities of the institution …within the broader context of society, history and the like” (Paterson, Osborne, & Gregory, 2004, p. 2). History and experiences identify how these connections are generated and perpetuated in nurses’ work. “The analyst considers how the settings of interest have emerged from a specific history – how things are organized this way rather than some other” (DeVault, 1999, p. 48).

Patriarchal traditions from the army and religious orders and the influence of hospital patriarchy are embedded in nurses’ work. “From its inception modern nursing has had a self conscious and limited speaking voice embedded in nineteenth century notions of the good woman” (Alavi & Cattoni, 1995, p. 344). It is important to understand how nurses’ work has been situated; an historical account reveals how nurses have been organized in the past. “The changing social relations of an historical process themselves determine the forms in which they come to consciousness” (Smith, 2004, p. 459). Although in numbers women still dominate in the profession of nursing, traditional roles and the patriarchal influence continue to be woven through their everyday work lives. “The subtlety of patriarchal power can obscure the experience of it” (Wall, 2007, p. 38). Therefore, exposing the ideologies and discourses that continue to linger assists in understanding their construction. Thus, IE and poststructuralism provide a means of discovering the taken for granted and make visible how power rules nurses and their work in acute care.
Research Within Acute Care

While I knew from history and my experience working in acute care that the prevailing patriarchal and positivist ideology organizes hospitals, it was surprisingly blatant in the ethics process.

Ethics approval procedures are not designed to cover the exigencies associated with a collective technique that is especially suited to collecting data on social relations in action. Rather, they are based on the assumption of pre-existing, perfect knowledge of the field. (Quinlan, 2008, p. 1497)

The Regina Qu’Appelle Health Region (RQHR) Research and Performance Support website states their philosophy as “all scientific methodologies (e.g. surveys, controlled experimentation) and all avenues of investigation (e.g. physical, psychological, social) have the potential to yield valuable information about health and health-related processes” (RQHR, Research and Health Information Services, n.d.). Further, the membership of the RQHR Research Ethics Board (REB) consists of “a minimum of five members, including men and women, with collective expertise in the areas of research, patient care, ethics, and law” (RQHR, Research and Health Information Services, n.d.).

The chair, a research scientist, appoints members. Given the fact that nurses are the largest number of employees in acute care, it is ironic that nursing is not included as one of the experts on the board. Before applying to the RQHR Research Ethics Board, I met with a research scientist to understand the required process. It was recommended that I discuss the study and research processes with the managers because they govern the units and the application requires their consent and a letter of support (see Appendix E); both were obtained. The managers recommended a process for communicating the study to nurses –by meeting with nurses in the afternoon because this was their slower time and also a time when short education sessions were conducted. After submitting “1 original
and 19 copies of the application form and other attached forms …along with 3 copies of the complete research protocol” (RQHR, Research and Health Information Services, n.d.), ethical approval was granted.

**Recruiting Nurse Participants**

Following approval, I arranged dates and times to come to the units to share information about the study, recruit nurses, and answer questions about this research with the managers. Recruitment posters (see Appendix A) were posted in each report room as per the manager’s instruction. Each time I arrived on the unit, the chaotic environment was evident in the noise, in the smells and, most obviously, in the pace of the nurses as they moved from patient rooms to medication carts and to other areas of the unit. *Had I not noticed this before?*

Each manager accompanied me to the unit for the first information session. The manager instructed the unit clerk to put out a call on the nurses’ pagers that an education session was taking place in the report room. Because it was an interruption from their work, only one to three nurses came to each of the sessions. Most of the time one nurse came, apologizing for being so busy. As I started to explain the study, another would come in, and I started again. Needless to say, I quickly learned what to say in fewer than 15 minutes. Many nurses were tentative about the study and several asked for whom did I work. Some immediately agreed to participate in the study, while others said they would think about it. From my experiences in acute care, several nurses knew me and two stated that if I was desperate for another participant to let them know. After eight information sessions and 25 potential participants, all women expressed an interest in being observed and provided me with their contact information. All wanted to be contacted via e-mail.
Following the introductory session, each nurse received an e-mail to confirm her participation; in the end, 18 nurses agreed to be observed. Together, we agreed on which shifts I could observe.

**Observation: Acute Care**

In keeping with the IE’s social ontology, data-collection methods need to “capture accounts of people actually doing things” (Campbell & Gregor, 2002, p. 78). Because one of my research goals was to discover what is actually happening where the nurses work and to ascertain how their work is shaped, observations were the first step in the process. IE explores how things work from the standpoint of those who live the everyday experience, in this study, women as nurses working in acute care. Diamond (2006) suggests that “almost all institutional ethnography begins in participant observation” (p. 59). Observations can help to “document the social power relations affecting gender…and epistemologically they can open up the gendered construction of knowledge” (Lawson, 1995, p. 450). The observations help in crafting the “stories…how ruling relations work, and particular ways for seeing the social organization in the local” (Diamond, 2006, p. 58). Based on my experiences, and because the majority of nurses working in acute-care work in medical and surgical areas (CIHI, 2008), I chose to conduct my research at the Pasqua Hospital, in the medical and surgical units.

The morning shifts began at 0730 hours. I arrived at the unit 20 minutes early, introduced myself to the staff, and waited for the nurse who I was going to observe. All nurses that I observed, but one, came to work at the same time that I that arrived. I asked each about their coming to work early, and each said it was a good way to organize her day. These discussions will be elaborated on in the analysis. After individual observation
informed consent (see Appendix B) was obtained, I observed each participant during her 12-hour shift. While I did not have a prescribed number of days observing, I wanted to come to understand what the nurses were “actually doing, regardless of how they understand and name their work within professional and organizational discourse” (Campbell & Gregor, 2002, p. 72). Observations focused on what the nurses did, with whom they interacted, and what they said during their day. In total, I observed 18 nurses 25 different times for approximately 6 to 8 hours at a time. By observing in the acute-care setting, I was actively involved in the social processes and the social organization of the nurses’ work. I was looking for recurring events and words that were used to explicate their experiences at work (Campbell & Gregor, 2002). This provided a start to understanding how ruling relations work or, as Diamond (2006) states, “participant observation can open up analytic aperture away from individuals and toward the coordination of their doings observed while doing them” (p. 61).

Further questions allowed me to uncover their hidden work.

The content of women’s spoken experience must remain open to exploration from a number of angles: first, as constructed knowledge from individual knowers; next, as an expression of a relationship to other knowers and multiple sites of power; and finally, as a site of inquiry. (Naples, 1999, p. 49)

For instance, while doing my observations, a nurse commented that the nursing unit “is always short-staffed.” This prompted me to ask the nurse to describe what working short-staffed is like. How does this influence her day? How does a nurse use the concept of the nursing shortage to organize her work and beyond? how does the nursing shortage operate within the hospital? This, then, becomes data for analysis in creating an understanding of how nurses are involved in ruling relations. I began to see how “always short-staffed” is acceptance and that normative power rules nurses’ work. “The research
is committed to exploring and exposing for consideration how ruling affects people whose everyday/everynight lives come under the influence of specific ruling practice” (Smith, 2006, p. 95). Throughout these observations, I journaled my reflections. “The research is to be carried out in a reflexive fashion from inside the social organization of not only our own world as researchers, but by extension, the social worlds we intend to investigate” (Smith, 2006, p. 173).

Field notes (FN)\(^1\) also helped in understanding “the local setting, the individuals that interact there and their experiences” (Campbell & Gregor, 2002, p. 60). I kept field notes about my observations in acute care to provide an initial understanding of how things are organized. In conducting observations, Campbell and Gregor (2002) suggest that in addition to making notes about what is happening, one also listens to the participants’ “talk that contains and expresses their expertise of living their lives” (p. 69). I listened for how a nurse talks about her work in acute care rather than why she is doing something. Informal interviews (II), or talking with the nurses, occurred during my observations. Opportunities to ask questions during observations are useful in understanding work processes (McCoy, 2008). If there were chances during the observations or at our break time, I asked nurses to describe what was going on and how she typically handled a given situation. I asked her to explain what she was doing and what she had to think about to do her work (DeVault & McCoy, 2002). For example, I observed one nurse discussing with her partner, a Licensed Practical Nurse, what they would have to do in their shift to care for a patient in the hallway. She explained that she had to consider the needs of the other patients, the admissions and discharges, and how

\(^{1}\)Italicized quotes, ending with the acronym FN, are from my field notes.
she would get her work done during the shift (see analysis for further discussion). This contributed to an understanding of what influenced and organized her day.

From my field notes, my journal, and the nurses’ descriptions of their day, I began to examine the institutional processes that organize how nurses work in acute care. From my field notes, I identified specific people who could further develop my understanding of the processes that shape and organize how nurses work. These people included managers, four charge nurses, a clinical-development educator, and a clinical resource nurse. In institutional ethnography, recursivity shows a pattern “and that is the organization that institutional ethnographers explore” (Campbell & Gregor, 2002, p. 69).

**Interviews: Listening for Ruling**

“The combination of observation and interviews, however is powerful because the researcher gets to see things happen, rather than just hearing about them; the participants can fill in with explanations about the parts that are not visible” (McCoy, 2008, p. 706). Individual participant interviews (PI) further explored what was actually happening to the nurses in acute care and how their work was coordinated as such. “Oppressive organizational practices are reflected in how people talk about their experiences in relation to the institution being studied” (O’Neill, 1998, p. 132; Smith, 1987). After an initial analysis of the observations, nurses were e-mailed about their availability to be interviewed. Of the 18 nurses I observed, 15 agreed to be interviewed. DeVault and McCoy (2002) describe front-line professionals (in this study, nurses) as “especially important because they make linkages between clients and ruling discourses” (p. 760). Nine interviews with nurses were conducted outside the hospital in collaboration with the

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2 Block quotations in the Calibri font, ending with the acronym PI, indicate quotes from participant interviews.
nurses of when and where it best suited their schedule. At their request, two nurses were interviewed over the telephone. Four interviews - two managers, one charge nurse and the clinical resource nurse - were conducted (at their request) in their office at the hospital. Prior to these interviews, consent was obtained (see Appendix C). The interviews were recorded to “aid in making notes and preserving details” (DeVault & McCoy, 2002, p. 758). Such interviews are valuable sources of learning about individual experience and help to identify and describe the social processes that occur in nurses’ work (DeVault & McCoy, 2002). “The interviewer’s goal is to elicit talk that will not only illuminate a particular circumstance but also point toward next steps in an ongoing, cumulative inquiry into translocal processes” (DeVault & McCoy, 2002, p. 753).

Prior to being interviewed, the nurses were emailed the interview questions. The interviews were conducted in a conversational manner, described by DeVault and McCoy (2002) as “talking with people” (p. 756). Open-ended questions (see Appendix D) guided the interviews, primarily based on what was learned from previous interviews (DeVault & McCoy, 2002). For example, in asking a question such as “Can you tell me about a typical day?” I paraphrased and checked my understanding (throughout all interviews) by asking, “When this happened, you did this. Is that correct?” (Campbell & Gregor, 2002). While I was guided by the open-ended questions, each interview grew from the last and from my reflections after each interview. Ethnomethodologically, I understand “conversational interaction to make sense of the interview as a jointly constructed verbal encounter” (DeVault, 1999, p. 100). While interviewing, I gave specific attention to the language of professional/institutional discourse in explaining work experiences and the way participants use institutional categories. I had to be cognizant of the fact that I, too,
am a nurse and, as such, speak in a specific language, “thus the interviewer must find ways of moving the talk beyond institutional language to ‘what actually happens’ in the setting” (DeVault & McCoy, 2002, p. 761).

I continued with the interviews until I had an understanding of how nurses’ work is shaped. For example, seven nurses consistently discussed how their work was influenced when physicians did their rounds on the unit. Of the 15 interviews I completed, each one lasted from 55 minutes up to 2 ½ hours. The point of conducting an interview is to learn about the nurse’s location in the relations of ruling and what the nurse does with texts. “IE interviewing is typically organized around the idea of work…the idea of work provides a conceptual frame and guides interview talk” (DeVault & McCoy, 2002, p. 758).

“From this initial exploration of people’s descriptions of their experiences, the researcher can identify specific sites, work processes, or discourses for further investigation” (Smith, 2006, p. 109). Thus, the interviews allowed me to begin to identify the rulings that coordinate nurses’ work within acute care (DeVault & McCoy, 2002). “No setting is an isolated unit, but is part of an organized whole. This underpins a strategy for identifying how power is inserted into (enacted in, actually,) the experiential setting, often in silent and mysterious ways” (Campbell, 2003, p. 13). Within the participant’s talk “is their tacit knowledge of how to do it, how to concert their own pieces of the work with the work of others and how to work with the texts that coordinate action” (Campbell & Gregor, 2002, p. 78). Level-two data are described as discovering the missing organizational details of how the setting works and understanding the broader setting (DeVault & McCoy, 2002). “Finding them, exploring what they do and how they
are organized to do it is how an institutional ethnographer discovers ruling” (Rankin & Campbell, 2006, p. 17). Other connections outside acute care were identified and researched to understand nurses’ work. Examples include, but are not limited to, the union and the professional body that control nurses’ work. The research process unfolds as the knowledge about how relations shape and organize nurses’ work is exposed.

**The Analysis: What Is Actually Happening?**

Because this study investigates the social forms of knowledge, coordination and control that shape nurses’ work in acute care, an analysis of the ideologies and discourses assisted in understanding how the ruling relations organize nurses’ work. The analysis focused on discovering the discourses and ideological practices that socially organize nurses and their work in acute care. McCoy (2006) discusses the importance of attending to ‘the how’ in understanding the institution. Thus, by adopting institutional ethnography and the feminist poststructuralist perspective, I was able to study the “processes of ruling through an analysis of how institutions and professional discourses exclude the standpoint of the” (Grahame, 1998, p. 349) nurses in their everyday/night work world. IE discovers how these categories of knowledge are enacted in nurses’ work in acute care. Institutional ethnography draws on the local experiences of nurses in analyzing how their work lives came to be “dominated and shaped by forces outside of them and their purposes” (DeVault & McCoy, 2002, p. 12). Feminist poststructuralism further assisted in understanding how nurses’ language produces and reinforces dominant ideologies of patriarchy (LeBlanc, 1997).

Nurses participate in the organizational order of the hospital. Their experiences identify how these connections are generated and perpetuated in their work. “The analyst
considers how the settings of interest have emerged from a specific history – how things are organized this way rather than some other” (DeVault, 1999, p. 48). Since hospitals are socially organized, employing a combined approach in data analysis revealed the underlying power structures, as well as how they operate and produce power that is coordinated in nurses’ everyday/everynight work. Nurses’ work is organized and coordinated by internal and external processes, many of which are invisible. Both approaches helped in understanding how power and social structure impact everyday situations. “Institutional practices lying within practicable reach can be identified” (Smith, 2005, p. 32). This combined perspective serves to uncover the ideologies and patriarchal way of looking at the social. It is important to note that this study did not objectify the nurse; rather, it allowed me to come to understand her work experience. This research was not an attempt to blame, but to focus on identifying and understanding how ruling organizes nurses and their work.

The historical perspective and the extensive critical literature review provided the initial information needed to give visibility to how knowledge, discourse, and ideology have taken form (Phillips & Jørgensen, 2002). “By drawing upon the historical …one can identify what is taken for granted within it” (Phillips & Jørgensen, 2002, p. 194). Linkages from the observations and interviews followed to explicate the dominant rulings that continue to perpetuate nurses’ work in acute care. “The analysis is a matter of moving back and forth between collected speech and the context that it was produced in” (DeVault & McCoy, 2002, p. 769). The ongoing data analysis assisted me in identifying the ruling discourses and in explaining how nurses’ experiences are shaped within the acute-care environment (DeVault & McCoy, 2002). “The analysis begins in experience and returns to it, having explicated how the experience came to happen as it did” (Smith, 2006).
Because it is assumed in this study that gender is an influence, the analysis further looked at how nurses and their work are constructed (Lather, 1992). “The analysis of the patriarchal structures of society and the positions that we occupy within them requires a theory which can address forms of social organization and social meanings and values which guarantee or contest them” (Weedon, 1997, p. 12). This approach exposed the ruling and work processes that shape nurses’ work experiences “without their explicit awareness but still with their active involvement” (Campbell & Gregor, 2002, p. 43).

Power relations and their effects are organized in everyday social practices and ideas (Smith, 2005). The feminist application further helped to identify the oppressive power relations that were heard in the nurses’ language (LeBlanc, 1997, p. 258). “These beliefs provided the theoretical foundation for feminists to challenge, examine, and deconstruct patriarchal discourse, social institutions, and power relationships that disadvantage and oppress women” (Arslanian-Engoren, 2002, p. 513). In using a feminist poststructuralist lens, I needed to pay attention to the constructions of gender, patriarchy, and their effects as the analysis focused on power and knowledge “as people’s organized activities” (Campbell & Gregor, 2002, p. 43). Together, feminist poststructuralism and institutional ethnography provide a “means of understanding, exposing and changing hierarchical social networks that use power” (Arslanian-Engoren, 2002, p. 513).

Beginning with the nurses’ experiences in acute care, these practices of ruling can be explained in the research account (Campbell, 2003). “By exploring the links between respondents’ experiences and the social relations which shape them, institutional ethnography can reveal how oppression is created, and maintained through the functioning of social institutions” (O’Neill, 1998, p. 133). The participant observations,
field notes, interviews, and my reflections recount and analyze the relations from the starting point of the local reality, the acute-care environment, describing how nurses’ work is organized within these relations. “The key is documenting everyday practices and linking those experiences to the larger macro structures” (McNeil, 2008, p. 110).

I transcribed all the interviews, which allowed me to listen to each nurse and to ensure that the transcripts were written in a way that protected the nurses’ identities. “The analytic goal is to make visible the ways the institutional order creates the conditions of individual experience” (Smith, 2006, p. 109). What words do nurses use to describe how they work in acute care? In keeping with IE’s ontology of the social, I listened to how the nurses talked about their day to identify the discourses or social relations that influenced their work in acute care. This provides an analysis “for those whose lives are subject to ruling relations” (Smith, 2006, p. 91). This approach uncovered the contextual, unseen discourses that support or limit nurses in acute care. “Scholars increasingly assert that organizations are discursive constructions because discourse is the very foundation upon which organizational life is built” (Fairhurst & Putnam, 2004, p. 5). Several themes became apparent, including the prevailing ideologies and invisible power produced in the many discourses that pervaded nurses’ work. This will be elaborated on in the next chapter.

Golafshani (2003) discusses use of several methods of data collection to help authenticate findings. In this study, the history; my experience and observations; as well as informal and individual interviews from different standpoints, on different unit locations, validated findings. This study neither seeks to generalize the experiences of the individuals interviewed nor does it examine how a particular phenomenon affects specific
individuals. Rather, it finds and describes the “social processes that have generalizing effects” (Smith, 2006, p. 18) and in this study the ideologies and discourses that rule nurses and their work. The generalizability of this study would be in clarifying how the institutional processes and ruling of nurses’ work in acute care are socially organized and shaped. In other words, how the ruling operates across various local settings, in this study, hospitals (Smith, 2006).

**Ethical Considerations**

Prior to undertaking the study, consent to carry out the research was obtained from the Research Ethics Board, University of Regina, and from the Regina Qu’Appelle Health Region and the Research Ethics Board. Written informed consent was obtained from the nurses prior to observations and interviews. The participants were assured that this research was to study their activities, not them, to understand how they are organized and ruled in their work (Campbell & Gregor, 2002). The nursing units were not named in the research and, because observations were performed in two different units, the likelihood of identifying the nurses was decreased. Confidentiality was assured through the use of pseudonyms throughout the written account. In keeping with ethics requirements, tapes were stored in a locked file drawer. As well, participants were informed that participation in this study was voluntary and that they had the right to withdraw or refuse to answer any questions at any time.

Although patients are at the core of nurses’ work, they were purposely excluded from the research process in this study. This is primarily for two reasons: to maintain patient privacy and to focus solely on the intent of the research. Because I was with
nurses in acute care, patients were inevitably part of my observations; however, my focus was to understand how nurses’ work is shaped by unknown forces in acute care.

**Conclusion**

Having explored several research methodologies prior to starting the research process, I determined a feminist poststructuralist perspective was the best approach to understand how ideologies and discourses influence nurses and their work. Because the patriarchal system is deeply rooted within acute care, using a feminist poststructuralist perspective further assisted in revealing the unseen power relations, while IE “sustains the material presence of people, allowing focus on discrete aspects of nursing” (Folkmann & Rankin, 2010, p. 3219). As well, this perspective assisted in understanding the social organization of nurses’ work in acute care.
CHAPTER 4: FINDINGS AND DISCUSSION

This chapter details the findings of my research. “Institutional ideologies are acquired...as methods of analyzing experiences located in the work process of the institution” (Smith, 1987, p. 161). McCoy (2008) discusses the value of combining observations and interviews in “studying institutional work processes” (p. 707). Together, the observational and interview data reveal how prevailing ideologies of patriarchy, efficiency, scarcity and selflessness organize and shape nurses’ work in contemporary hospitals. “By exploring the links between respondents’ experiences and the social relations which shape them, institutional ethnography can reveal how oppression is created and maintained through the functioning of social institutions” (O’Neill, 1998, p. 133).

The concept of work, as described in an earlier chapter, is central to the analysis and discussion of understanding nurses’ actual work. “Gender issues are not simply determined by the distribution of gender in the profession …but also by the nature of the work and its associated connotations” (Tosh, 2007, p. 75). In this research, I found that much of nurses’ actual work is shaped by the prevailing institutional ideologies and discourses of acute care. These concepts create institutional discourses that are not abstractions but the means by which social relations organize nurses in acute care (Smith, 1990a). Overcapacity, staff shortages, increasing patient acuity, and budget constraints are common discourses surrounding nurses’ work in contemporary hospitals. Nurses actively participate in maintaining their normative power. These discourses invisibly control and shape how nurses work in acute care. The analysis focuses on “addressing, ideas, concepts, beliefs, and so forth as expressions of actual social practices, as things
that are spoken, written, heard or read in definite local historical contexts” (Smith, 1990a, p. 62). Thus, this research provides insight into my understanding about how the historical influences, institutional structures, and the work processes shape nurses’ work today.

The analytic process, as discussed in the previous chapter, begins with my experiences and the historical context before moving to the literature to understand the conceptualizations and the objectified knowledge of nurses and their work. “Objectified knowledge, as we engage with it, subdues, discounts, and disqualifies our various interests, perspectives, angles, and experience, and what we might have to say speaking from them” (Smith, 1990a, p. 80). As the constructions of nurses and their work becomes obvious, the analysis continues with the next level of data: the observations and the interviews. Central to the observations and field notes was the patriarchal power that nurses talked about when discussing their work. Nurses’ work is focused on patients; however, much of their work is also dedicated to maintaining the business of the hospital that is driven by the physicians. Within acute care, nurses’ work is largely controlled by others. The institutional discourses and inherent power relations make it almost impossible for nurses to see how they participate and absorb the work of others.

Constructed as the nurses’ problem, ruling, or nurses’ participation is activated by institutional discourses. Discourse “is often conceptually linked to others in providing for coordination and articulation of institutional events” (Griffith, 1995, p. 110). This discourse situates nurses and their work within the discursive relations of the hospital (Smith, 1999). Power relations are exercised through unseen rulings as nurses are expected to absorb the hospital’s problems into their work. Unknowingly, nurses
“participate in a standpoint within the relation of rulings, creating a knowledge apt for ruling” (Smith, 1987, p. 212). Nurses are organized to constitute this as their normal everyday work and have become objects of this discourse. Nurses participate in the discourse that rules their work and they create processes that perpetuate this discourse. “Discourse is largely synonymous with the ideology by which the ruling class maintains its position through presenting its own interests as though they were exactly the same as those of everyone else” (Newton, 1995, p. 7). Nurses have accepted a form of work imposed on them in an historically embedded patriarchal system that operates overcrowded, understaffed, Monday to Friday, on a budget, and in an environment that seems to ignore them, yet influences their work. This research does not seek to objectify nurses or cast blame; it does, however, make known the unseen powers that influence and dominate their work in hospitals. This research sheds light on how nurses and their work connect to the relations of power, labour, and gender that produce an organization of power as the concerting of people’s activities and the uses of organization to enforce processes producing a version of the world that is peculiarly one-sided, that is known only from within the modes of ruling, and that defines the objects of its power. (Smith, 1990a, p. 84)

Thus, the following chapter combines the findings through discussion as a means to reveal what was observable, together with the nurses’ descriptions of their understanding of the institutional work processes that rule them and their work (Smith, 1987, 2006). “In an institutional ethnography (IE), the findings and discussion are methodologically and theoretically linked” (McGibbon et al., 2010, p. 1354). To understand ruling, I begin the discussion by making known the influences that continue to pervade nurses’ work. This is followed by the analysis and discussion of where nurses work and what contributes to organizing and coordinating their work in the hospital.
Besides the observations, data from the participant interviews assist in supporting the findings by revealing how prevailing ideologies and institutional discourses activate ruling. Throughout, italicized reflections from my field notes and experiences are included as an extension to understanding the social organization of nurses’ work (DeVault, 1990; Smith, 2006). “Indeed, where one stands determines what one experiences, shaping to an important extent what can be known” (Campbell, 2006, p. 94).

**Lipstick on a Pig**

Hospitals have undeniably evolved over time, yet many historical influences continue to exert control and power over nurses and their work. Years of oppression, reform, and hierarchal dominance constitute part of the institutional discourse that controls nurses’ work. Ruled by a gender subtext, the predominantly female nursing workforce, unarguably remains organized by the power of hierarchal structures and subordinate relationships in hospitals. “Poststructuralist feminism requires attention to historical specificity in the production of women, of subject positions and modes of femininity and their place in the overall network of social power relations” (Weedon, 1997, p. 131). Much of nurses’ work is assumed to be a normal part of their day with much of its attention perfunctory. “The historical undervaluing of women’s work has laid the foundation for the practice of undervaluing many aspects of nurses’ work” (McGibbon et al., 2010, p. 1374). As domestic work, much of nurses’ work is unseen and without their awareness (McGibbon et al., 2010; Rankin & Campbell, 2006). “An examination of some institutional ideologies suggests indeed that the work processes of actual individuals are specifically obscured” (Smith, 1987, p. 162). Assumably, hospitals have evolved, yet they continue to operate much like they did in earlier times.
Problems of overcrowding, increasing patient acuity, the nursing shortage, early patient discharge, and cost-containment measures have been organized as nurses’ problems. These “concepts or ways of thinking, naming and knowing, coordinate and make possible the process of institutional articulations and absorption” (Walker, 1990, p. 64). Invisibly, nurses assume these as their work and, in so doing, enter into relations that rule their work. “Ruling takes place when the interests of those who rule dominate the actions of those in the local setting” (Campbell & Gregor, 2002, p. 36). Nurses have come to know this as just part of their day and accept this as their work.

Besides the sustaining power of the patriarch, the restructuring initiatives that took place in the 1990s continue to impact acute care. It is now 20 years since the reform, and skeleton staffing still persists while hospitals tout safe, quality patient care. Nurses still discuss the workload, staff shortages, and the pressure to save the hospital money. Today, to address the budget and the hospital inefficiencies, nurses are tasked with having to integrate government and managerial-led initiatives into their work. Efficiency and economy have become nurses’ problems to manage. The discourse of the budget and efficiency are like that of the health care reform of the past: Target the individual nurse. “As I began to understand what these women were saying, I also began to see more clearly how standard vocabulary...really doesn’t describe what they do” (DeVault, 1990, p. 103). This research demonstrates that old problems continue to be plague nurses’ work while new problems emerge which force nurses to adapt and accept adversity as just part of their work.

I must be in a time warp...really, is it 2010, WHAT has changed? A few computers? Nurses hurrying about...talking with colleagues in the hallway, standing at the medication carts, entering and exiting patient rooms, admitting,
discharging, moving patients, walking with physicians while scribbling notes on a clipboard. (FN 2)

Preserving Embedded Patriarchal Ideology Through Nurses’ Selflessness Discourse

Relations of power are situated “in their historical particularity” and “are made accountable in terms of categories and concepts expressing the function of the institution” (Smith, 1987, p. 161). The relations of power and gender influence nurses’ work in many ways, yet most evident during the observations and interviews were the power relations associated with the embedded patriarchal ideology within the hospital. “Mainstream institutions claim to ignore gender differences, in fact, they implement a patriarchal ideology that handicaps women” (O’Neill, 1998, p. 132). Considered normal, their oppressive effects rule nurses’ and their work in hospitals. Power operates and is sustained by normalizing much of nurses’ work in hospitals.

Ultimately, this provides “a starting point for unveiling what lies behind – for helping us uncover gender and class relations at work, and to understand the complex interconnections” (Davies, 2003, p. 721). Repressive power and systemic oppression continue to organize and control much of nurses’ work. “Oppressive organizational practices are reflected in how people talk about their experiences in relation to the institution being studied” (O’Neill, 1998, p. 132).

The social organization of internal hierarchies and the influencing institutional discourses “both recapitulate and perpetuate historically established gender relationships” (Smith, 1990a, p. 99). Disguised as part of their work, patriarchal relations are unnoticeably woven through nurses’ everyday experiences. “In the health care field, patriarchal standards have reigned and the personal experience of professional caregiving
has been devalued” (Wuest, 1994, p. 364). Embedded and mediated by the institutional structure, nurses continue to be ruled by a patriarchal system. “Traditional relations still hold sway to a large extent – relations that were initially premised upon doing dominance and doing deference” (Davies, 2003, p. 723).

A long history of inherent patriarchal processes has produced docility in nurses. Nurses have learned to obey orders and practice in a manner that is prescribed by others. “The practice of nursing today has been strongly influenced by the historical development of the practice within hierarchical, autocratic, oppressive institutions” (Fletcher, 2006, p. 50). While it is recognized that nurses work in a hierarchal system ruled by patriarchal ideology, nurses’ altruistic ways remain evident in their working relations. “What is important to note, however, is the conditions that are critical for sustaining patriarchy” (Rafael Falk, 1996, p. 4). Controlled by unseen power relations, nurses continue to go about their everyday work much as they did in earlier times. The “specific historical character ideology builds the internal social organization of the ruling class as well as its domination over others” (Smith, 1987, p. 57). This alignment of power occurs naturally in hospitals because the majority of nurses are women. “Since its rise as an organised profession nursing has long been regarded as one of the archetypal female occupations” (Porter, 1992, p. 511). The following interview excerpts demonstrate nurses’ participation in enabling the embedded patriarchal relations to persist within the hierarchal structure.

I’ll have physicians there and they are your priority so you just don’t get there, okay. (PI 1)

I try not to make any calls to physicians before my breaks...some of them only like talking to the charge nurse. (PI 4)
I know more or less what my manager would want me to do (PI 10)

If you don’t go they [the physicians] get mad. If you don’t, they go do rounds on their own and they miss a whole bunch of things...that you’ll just have to end up calling them for, anyway...so...like there’s often re-orders for medications and they don’t look at the re-orders themselves...you have to tell them...for the most part you have to say this is up for re-order...this is up for re-order...so if ...you don’t go with them...they don’t get the re-order and then it falls off the MAR so we have to make sure we do the re-orders each day. (PI 9)

Although it is true that there are more female physicians, managers, and others in today’s hospitals, nurses and their work remain entrenched in traditional ideologies.

“Gender issues are not simply determined by the distribution of gender in the profession in question but also by the nature of the work and its associated connotations” (Tosh, 2007, p. 75). With the legacy of historical ideations of selflessness, nursing has long been assumed to be the work of women who are “subordinated within this generalizing discourse” (Griffith, 1995, p. 118). This unseen discourse provides the language for coordinating nurses’ work in hospitals. “Although the feminist movement of the 1960s did much to bring women in other professions on an equal footing with men, nursing’s low status in the health care hierarchy remains” (Manojlovich, 2007). If nurses’ work is believed to be based on selflessness, then it is easy to take for granted their actual work in hospitals. “Through selective treatment of actualities they construct accounts of history and society as expressions of concepts” (Smith, 1990a, p. 34). Nurses support the patriarchal system by enacting these discourses that “organize relations among subjects active in the discourse” (Smith, 1987, p. 214). Tired from past attempts to provide solutions, nurses believe that nothing will change and no one is listening so why even bother. Nurses contribute in ways that comply with the embedded patriarchal ideology that relies on the discourse of selflessness and gendered work. Nurses come to see these
relations to their work as natural and normal. “Nurses were carefully taught to put this commitment above material concerns such as pay or holidays, above concerns about physicians' competence or power, and above concerns about conditions of work.” (Armstrong, 1993a, p. 315). Nurses’ comments reveal their acceptance with the conditions of their work.

I just suck it up and get through it and do what I need to do...I usually don’t say anything because I find it’s not worth it...because it’s not gonna change or do anything...I don’t know...that’s probably not the best...but I know. (PI 11)

Well it’s never going to change...like spending more time with patients or providing better care. You really can’t do anything...you can’t make the doctor come at 1 o’clock. (PI 12)

If I find someone in the med room crying...good...you got it...so give ‘em a hug...tomorrow will be better...just come back tomorrow...and you won’t be as scared tomorrow. (PI 2)

Working the Space of Acute Care

Nurses work within the physical space of the hospital, with the majority of their work confined to the space of the units or wards. During my observations, I noticed power relations within the gendered space of the hospital. “Gendered space is a literal and metaphorical space in which the concerns and interests of a certain gender are rendered invisible” (Liaschenko, 1997, p. 47).

Space always impacts our day and on a busy day, when you have a thousand doctors coming in and out and they need their quiet, they need their space, they need to dictate and they don’t have it...so it’s constant interruptions and that impacts a day and anything for time. (PI 4)

Nurses, mostly woman, are the largest group of employees of the hospital who work closest with patients 24 hours a day, 7 days a week, yet they have surprisingly little space in which to do their work. Nurses work within a controlled structure that ignores
their needs but largely shapes how they work. The context can reveal and “reflect power relations, and issues of power can be addressed in spatial terms” (Tellioğlu & Wagner, 2001, p. 163). Oddly, a good part of nurses’ work is done in the hallway, an area that is noisy and busy with people coming and going. Work in the hallway includes standing at the medication cart for long periods of time; charting at a makeshift office made from a patient’s overbed table and chair without arms; talking on telephones which are located on the walls of the hallway; conversing with colleagues; and, moving quickly while dodging equipment and people to get into patient rooms. When the hospital is overcapacity, the hallway also becomes an area where patients are cared for.

Besides a place where nurses do their work, the hallway is also used to store equipment such as a crash cart, mechanical lifts, and isolation carts. Other hospital staff members who also do their work in the hallway include, but are not limited to, housekeeping, service aides, pharmacists, physiotherapists, and laboratory and diagnostic technicians. For example, housekeeping staff drive the noisy Zamboni-like cleaning machine down the hallway once a day, usually in the morning, which is the nurses’ busiest time of day. Twice a day, the service aide rolls the 8-foot high by 6-foot long supply cart down the hallway. At meal times, the nutrition staff wheel the meal carts down the hallway dropping off meal trays to the patient rooms. Laboratory technicians enter and exit patient rooms, frequently asking questions of nurses, and physiotherapists walk with patients.

My hips, back and feet ache during the hours of observations. Several nurses offer me a chair, I refuse, and recall what it feels like to stand and move quickly for hours at a time.

Nurses whizzing by, I attempt to move out of their way, the hallways are narrow, filled with equipment and all the noise. Driving home, I notice my sensitivity to
cars, sound …my mind and heart continues to race. I have trouble sleeping at night. (FN 12)

Nurses also work in patient rooms. Most patient rooms are crowded with two beds, intravenous equipment, wheelchairs, chairs, commodes, walkers, and other patient supplies. The areas are cramped and require careful navigating. Nurses have learned to adapt and skillfully move their bodies to accommodate the restricted space. Hospitals are not structured to accommodate nurses’ work, leaving nurses to adapt or become injured. It is apparent that nurses are expected to work in a confined, busy, and noisy environment while attempting to concentrate on the details of patients, medications, and colleagues.

For a second, I recall back to the regular occurrence of bruises on my arms and legs. I just considered this a result of working in cramped space…until now. (FN4)

Nurses listen to report in various locations on the unit. These include spaces that were once patient rooms or even a tub room with ceramic tiles and pull-light cords still in place. Another room doubles as the staff room, while staff come and go during report. The patient lounge, which lacks a door, is another area for report. Because maintaining patient confidentiality is part of nurses’ work, nurses accommodate this space by talking quietly during report. When nursing students are on the unit, the service aide’s room provides the space for a group to listen to report, everyone standing for the 30-minute duration because of a lack of chairs.

People usually fight for the back room…it’s the nicest place to sit and have your coffee in the morning…while you listen to report. (PI 3)

We split up some little back rooms back into our corner…each team is assigned to a specific corner to listen. (PI 3)

In contrast, managers, physicians, pharmacists, social workers and other health-care staff, most of whom have their own offices outside the units, use the nurses’ station,
which resembles an open office space, to do some of their work. This space has chairs, desk space, computers, office supplies and is designated for hospital staff only. Except for the charge nurse, most nurses do not use this area. Although they are subject to the rules about who has which space, how much space, who can go where and for how long, the meaning woven around hospital spaces and the daily uses that individuals make of them are never totally inscribed within the hospital rule book. (Halford & Leonard, 2003, p. 202) The lack of working space reveals the inherent social order of nurses in the hierarchy. “Nurses may be confined to the wards whilst doctors have the freedom to roam, but the constant and territorial relationship that nurses have with ward spaces constructs doctors as visitors” (Halford & Leonard, 2003, p. 205). The use of space results from a hierarchal system that accommodates one group while negating the needs of another. Differences illuminate the power relations that control where nurses do their work. It is clearly assumed that nurses will work in confined chaotic areas. Our ward is such a mess...there’s always things in the hallway no matter how nice you try to make it look...it’s still a mess...it always looks disastrous... space...and I think every ward should have a staff room.(PI 9) Other than accompanying patients to other areas in the hospital, most nurses leave the unit only to go to the cafeteria on their assigned breaks. Located in the basement of the hospital, the cafeteria is noisy, busy, and open to the public. Space is a discourse that is performative of ruling power relations. Little space indicates a low-status identity, whereas the right to go anywhere and access other’s space is productive of high status. The space battle is not simply an inconvenience; it enacts and confirms nurses’ status in the hospital hierarchy. The observations and nurses’ comments reveal how space organizes and shapes their work.
Unlike nurses, physicians are not employees of hospitals, yet within the hospital they are provided with many conveniences including, but not limited to, a physician-only lounge located away from patient care units; parking in close proximity to the hospital; and, phones and computers designated for their use only on the patient units. “Working in independent practice, and paid a fee for each service, doctors cannot easily share work with nurses, nutritionists, mental health counsellors or other professionals” (Fyke, 2001, p. 10). Depending on where you situated in the hospitals, space is used very differently. Hospitals support the ruling patriarchy by organizing physicians and their work as separate from the hospital.

Nurses use their handheld devices; however, unlike physicians, managers, pharmacists, and other hospital personnel, they are not allowed to use the devices on the unit; instead they must use them during their break times. The policies governing nurses are not any different than those of other employees in the hospitals, yet unseen power relations repeatedly reveal where nurses are situated in the hospital hierarchy. As employees of the hospital, and good women, nurses follow the hospital’s policy on the use of cellular phones and wireless communications and accept this as normal. “The social relations of dominant and subordinate professions and their gender subtext has been carried forward into the virtual realities of public, textually mediated discourse” (Smith, 1990a, p. 103). The policy maintains the nurses’ place and further supports the patriarchy. “Policy procedures disconnect people from knowledge...of class and gender relations” (Mueller, 1995, p. 105). Apparently, other hospital personnel’s cell phones have resistance to electromagnetic interference (EMI), while nurses’ devices are a “potential source of EMI” and “could cause or contribute to the serious illness, injury or
death of the patient” as outlined in the RQHR policy 601 (see Appendix G). Privileges and access to social space reveal the social order of nurses in the hospital. Ironically, nurses, who comprise the largest group in hospitals, are marginal players in the hospital hierarchy. “Thus the institutions that lock sociology into the structures occupied by men are the same institutions that lock women into the situations in which we have found ourselves oppressed” (Smith, 1990a, p. 14).

The Hidden Work of Obtaining Patient Orders

“It is no secret that nurses are located differently from physicians within the relations of the health care system” (Rankin & Campbell, 2006, p. 10). Obviously, the internalized patriarchal ideological discourse influences nurses’ work and is essential for situating them within the institutional structure. This metadiscourse ultimately regulates and organizes much of the work of nurses in acute care (Smith, 2005). “While it may not be comfortable for those involved, it is important to recognize that well-intentioned work may be part of the oppressive relations of ruling” (Campbell & Gregor, 2002, p. 39). This discourse relies on the history of nurses’ altruism and the unseen work done by women. Ruled by embedded ideologies, nurses’ “well-intentioned work may be part of the oppressive relations of ruling” (Campbell & Gregor, 2002, p. 39).

Some just require you to accompany them to the patient’s bedside…it’s an old doctor thing but it’s good for communication sometimes…it’s just good for the doctor…it is helpful. (PI 4)

It makes it a lot easier if you drop everything and just go with them…it’s a lot more work if you don’t. (PI 9)

I observed how the hidden power relations became apparent as nurses participated in the work of physicians as simply part of their routine. “Hospital work processes
depend materially and conceptually on the nurse engaging in the work of others” (McGibbon et al., 2010, p. 1365). For example, every night after reviewing each patient’s chart in depth, nurses create a list known as ‘the ask list’ for each physician. These lists are given to the day charge nurse who adds other patient needs before giving it to the physician. She clips each physician’s list to his or her patient’s chart. This procedure is an example of physicians’ unseen power and control as nurses seek their approval for the items on the list. Nurses describe the ask list as a means of communicating and obtaining patient orders from physicians. Examples of orders include the need for medications, medication reorders, physiotherapy, diagnostic tests, discharge and blood work.

The night shift will typically make up...it’s called an ask list. So it will have all the doctors and their patients on there and then if the night shift finds something wrong on their night checks with the patients or they think, you know, this patient with pneumonia is really struggling to breathe, we get some nebulizers ordered. They’ll write it on the ask list. Typically, the family doctors come in early before they go to their office and umm...you’ll have your ask list there and you can check with them and ask them for that...it’s nice to catch them when they’re there...rather than phoning them later in the day for something. (PI 10)

The ask list is an example of the dominant, historically embedded relations between nurses and physicians. The nurses’ place “is evident in the social relations of power in the nurses’ experiences of negotiating their way through patient-care decision making” (McGibbon et al., 2010, p. 1368). Filtered by nurses’ altruistic powerless discourse, my interviews revealed how nurses are shaped by insistent patriarchal relations discourse. The “discursively-organized relations permeate informants’ understandings, talk, and activities” (Campbell & Gregor, 2002, p. 90). Nurses describe physicians as busy, thus the list becomes a means of obtaining patient orders and facilitating the work of physicians. However, in creating the list, nurses maintain their place in the social order of the hospital while sustaining the physician’s position of power.
Nurses can ask; however, it’s the physician who controls by deciding on orders. “Authority is a form of power that is a distinctive capacity to get things done in words” (Smith, 1987, p. 29). Physicians give the orders and nurses take them. This work process maintains the historical roots of patriarchal power. “Women are outside the extralocal relations of ruling, for the most part located in work processes that sustain it and are essential for its existence” (Smith, 1987, p. 79). Nurses enact the altruistic discourse which assumes that physicians’ work is more important and takes priority over nurses’ work.

When a physician arrives on the unit, the charge nurse or another nurse stops her work and, on most occasions, reviews the list with the physician. Should more than one physician arrive at the same time, they will wait their turn, ask another nurse to assist, or take their list and proceed to see their patients. Nurses describe the list as a means directing the physician without having to accompany them to patient rooms. Yet, more times than not, during the observations, it was noted that nurses would ask physicians if they needed to be accompanied. Nurses expressed that accompanying the physician was a way of knowing what was going on with the patients.

We complete the ask list and there are lots of times that we can have two or three physicians at the same time so if they have list that is very clear and concise of the things that we need, then they can at least be a little bit more independent, too, to do some of their work on their own. (PI 1)

Nurses make important assessments of patient needs; however this knowledge translates to a request for consideration. While the nurse walks alongside, the physician reviews the list, sees or does not see the patient, and writes or does not write the order. These ward rounds are “a powerful ritual in health care” and have “traditionally been used to preserve the dominance or hegemony of the medical position in health care
decision-making over team members” (Coombs & Ersser, 2004, p. 246). Nurses participate in maintaining the hierarchal relations and handmaiden ideology by minimizing their knowledge and potential authority. The nurse then takes the chart to the desk of the unit clerk for processing of the order.

“Physicians are not required to consult nurses or take their opinions into account” (Moland, 2006, p. 55). Conversation is minimal between the nurse and the physician during rounds. Patriarchal ideology maintains relational power as the nurse is subservient in the communication process. One nurse states “It’s is no big deal to not look at me or even talk to me...[the physician] just grabbed the sheet..I can look at the orders and talk to the patients later.” Nurses behave as directed by the physician. Another nurse commented that the physician’s mood is considered an indicator of being able to obtain the orders on the list. “If the physician is in a bad mood you might not get what’s on the list.” Another nurse states “we doctor now, not nurse.” Covert power operates in this relationship by keeping the nurse subservient to the physician. “Women are expected to dispense their interpersonal services in addition to their other services” (Daniels, 1987, p. 409). Nurses are assumed to be obedient and carry out the orders without much question. “It is no accident that women are identified with the world of feeling and emotion, not only as being more emotional than men, but also creating and preserving for men” (Smith, 1987, p. 65). Much of nurses’ unseen work includes that of the “doctor’s assistant, devoted Christian fulfilling a vocation, and archetypal good nurse” (Fealy, 2004, p. 652). Nurses maintain and act upon the embedded patriarchal working relations to obtain patient orders. “At best we have played a subordinate role, being accorded the manual and nonspecific tasks that are essential to its functioning” (Smith, 1987, p. 153). Unaware of
the unseen patriarchal power, nurses accept this as their work, while it is assumed they will participate and accommodate physicians in obtaining patient orders. “Personal experiences of oppression are anchored in and sustained by a patriarchal organization of ruling” (Smith, 1987, p. 211).

One day while I was observing a nurse doing patient rounds with a physician, the physician turned to me and asked what I was doing. After I explained my role, they continued on while I continued to observe; within a few minutes, the physician turned to me and again asked about the observations. Again, I explained. The physician finished doing rounds with the nurse and left the unit. A few moments later, the nurse’s phone rang. I could overhear someone talking loudly, however, couldn’t make out what was being said until the nurse explained repeatedly to the caller “She is researching nurses’ work and not physicians.” The nurse completed the call and explained to me that the physician did not want me around when doing patient rounds. I apologized to the nurse and stated that I would speak to the physician, however, the nurse went on to say “Don’t bother, it’s not worth it. (FN 18)

The Work of Knowing the Physician’s Schedule

During my observations, nurses were continually asked by patients, families, and other hospital staff when they expected the physician to be on the unit. Within the hospital, nurses remain socially organized to be subservient to the regime of the physician. They are understandably expected to work with physicians; however, it is always at the physician’s convenience. This one-way relationship is evident in their work relations.

Should they come, but that’s what consumes a lot of your afternoon because the doctors come in the afternoon and that’s when you have a lot of your new orders and you have to implement in the afternoon. (PI 3)

Nurses do not know when physicians will be on the unit to do their patient rounds and have come to expect their arrival at any time during the day or night. However, the nurses’ comments reveal how they participate in supporting the physician’s schedule.
Sometimes the doctors come early in the morning so you kind of have to leave your report and go make rounds with them. They'll just show up whenever. Sometimes you can look at the OR slate and see if a specific doctor is in the OR....ummm....in the morning or in the afternoon, then you know that they'll probably come in the morning to do their rounds but that’s really the only thing you have to guesstimate when they might come. They usually show up whenever, and it also depends on their day as well, their office, they still may do their office or maybe sometimes the GI unit, they’re all over the place, and they don’t tell us their schedule. (PI 9)

When you’re on the floor...you don’t always see the doctor coming and going...they might be in a totally different part of the building where you can’t see those coming and going. (PI 5)

They come at midnight to do rounds...when patients have...we’ve settled everyone in...and analgesic and midnight, come and do rounds. So that happens...not very often but...we have one that is notoriously late. (PI 6)

There are some that just pop up on their own and you might not see them and you end up having to call them anyway...a lot of x doctors ...a couple ...they’ll just pop up and leave and then you don’t know that they’re here until you go through the charts and see that they wrote some orders...sometimes you’ve missed them because you end up phoning them as well...the big thing is usually waiting for phone calls...you put out a phone call to the doctors ...oftentimes they don’t get back to you so you’re waiting for them to call back soon but there are some that will take a long time to call back. (PI 4)

You don’t even know if they’re gonna come up that day. (PI 9)

All day we’re just waiting for doctors putting out calls. (PI 1)

When’s the doctor coming?...that’s what everybody asks (laughs), when is the doctor coming...and when are they getting out...and we have no idea when they’re getting out...because we have to know everything else first right (laughs)...but, yeh, you get lots of inquiries and sometimes there’s the same questions and it’s rather frustrating when know, you really can’t do anything, you can’t make the doctor come at 1 o’clock every day, but yet, they just think that you know, we should have the magic and we should be here at 2 o’clock exactly but yep that would be the perfect world but it doesn’t work like that of course. (PI 5)

Nurses are expected to wait and be ready while physicians come and go in the hospital. “Institutional forms of discourse create relations between subjects appearing as a
body of knowledge existing in its own right” (Smith, 1987, p. 214). Nurses are given partial knowledge about the physician’s office hours, procedures, and operating rooms schedules, so they often guess when physicians might be on the unit. Nurses know that each physician has a different schedule that can change without any notice. Should there be a need to contact a physician, the nurse will attempt to piece the information together.

The doctors don’t tell us when they come...they just kinda show up ...some you can guess if they’re in the OR all day on the slate...okay, you can kinda know they’ll come later on in the day but for the most part, no...and it’s kind of frustrating because families are always asking when is the doctor coming because they wanna be there to talk to them...or ask questions...but ...(you try to be the go-between)...yeh...you say I don’t know...it’s frustrating for us because we don’t know when they’re coming. (PI 6)

There’s a few that kind of come earlier in the day...but you never know...sometimes...you don’t even know if they’re gonna come up that day...ummm...the GI doctors are so busy. There’s a shortage of the GI doctors right now...so they’re always on the GI unit...and they’re scoping people all day so then it’s hard to know if they’re gonna come to the unit...sometimes they won’t have ahh...a patient on your unit...but they may have scoped a patient on your unit...ahh...if they were consulted...ahh...so if you have to call them...you will call them on the GI unit...leave a message for when they have time to call us and sometimes you do a lot of phone orders ...which can be difficult sometimes, too. “I especially find myself telling the patient ...you know ...we don’t know when doctors are coming, you know...they’re always...like [asking]...when is the doctor coming, when is the doctor coming. I don’t know, (laughs) they come when they want...and you know... no, the doctors don’t tell us when they come...they just kinda show up. (PI 12)

They come when they come and a lot of that is based on their OR time or their office time. Everyone is kind of different...most of the doctors are pretty much operating every day or at least someone is...so they come between cases or they don’t come until 10 o’clock at night, and stuff like that can really throw a wrench into the day. (PI 9)

Limited by this lack of knowledge, nurses are ruled by patriarchal power. It is simply assumed that a nurse will be available for physicians and assist with their work when they arrive on the unit. This implies that nurses are available at any time; their work
is not considered important and can, therefore, be interrupted. “An outdated, burdensome model of monopolistic control originating in a gender-stereotyped division of labor from previous centuries is still lumbering along” (Group & Roberts, 2001, p. xlv).

Hidden as part of their work, nurses are expected to know physicians’ schedules, their routines, holidays, and their office and work hours as part of their everyday knowledge. In contrast, physicians expect nurses to be available at any time of the day or night to accommodate their schedules. “Such a social organization of knowledge is integral and essential to the organization of large-scale enterprise, government, and profession and to the organization of a discourse” (Smith, 1999, p. 51). The social order of physicians and nurses in the hospital creates different expectations of time and the organization of work (Smith, 1987). Nurses remain organized to be subservient to physicians’ work. This maintains the hierarchal ruling power by “the men occupying the institutionally defined positions of power and authority within it” (Smith, 1999, p. 220). Having nurses respond to each physician’s schedule means that the hospital’s social order persists in keeping nurses’ work “anchored in and sustained by a patriarchal organization of ruling” (Smith, 1987, p. 211). Nurses participate in maintaining this subservient relationship by not only deferring to each physician’s routine but also accepting this as a normal, ordinary part of their work. “Typically the relationships of super- and subordination in these relations both recapitulate and perpetuate historically established gender relationships” (Smith, 1990a, p. 99). Patriarchal relations preserve nurses in the time warp of the hospital hierarchy. Similarly, to the good wife who mediates between the family and children, the selfless nurse is ruled by obedience to the physician’s
schedule. This upholds the physician’s reputation and their position of authority over nurses.

**Team Work and the Generic Patient**

Nurses begin their day by checking the patient assignment sheet, which lists the number of patients and rooms for which they will be responsible during their shift. The sheet also lists with whom they will be working for the day (see Appendix F). On most days, a Registered Nurse (RN) and a Licensed Practical Nurse (LPN) work as a team of two to care for their assigned number of patients. Nurses are unsure of how the assignment is determined, and most say they don’t have a choice in the assignment. One nurse says it is alphabetical, while another says it is done in the order of your name on the work schedule. The manager or the charge nurse creates the patient assignment sheet before the nurses come to work.

The manager makes up the schedule. I have no clue how this is done. You come to work in the morning and you are told who are working with and with whom you are working with...just by looking at the sheet and you have no say in that. (PI 2)

You have to check on where you are assigned. (PI 7)

Our manager makes up that every day so we don’t really have a choice. (PI 13)

I was once told we were assigned alphabetical of our last names. (PI 3)

The hospital hierarchy and authority relations become apparent in locating each nurse in the actual social process of unseen ruling. “Traditionally, those in the most powerful social positions have had the privilege of having their perspectives or standpoints become the dominant knowledge sources” (McNeil, 2008, p. 110).

Because nurses verbally report to each other at the end and at the beginning of their shift, nothing about the patients’ needs is listed on the patient assignment sheet.
Invisibly, the patient assignment sheet adds to the construction of the generic patient that also hides the nurses’ actual work. Increasing patient acuity has become common hospital discourse yet, “a sophisticated form of power is exercised over nurses and their work” as hospitals ignore how acuity actually influences the work of nurses (Rankin & Campbell, 2006, p. 19). Recently, to address increasing patient acuity, nurses began working as teams of two when the patients became heavy. In doing so, nurses create a work process to manage the extra work associated with heavy patients.

We divide up the work so it’s not so heavy. (PI 2)

We do our completes together…it’s hard on your body to do a complete. To roll someone back and forth with someone is easier to have two people and hold somebody over, let’s say washing their back…it’s a lot easier, it’s a lot nicer to have to do it with someone than to do it yourself. (PI 3)

Heavy actually means patients who are seriously ill, older with multisystem health conditions, obese, or in isolation which creates extra work for nurses, much of which remains unseen. Heavy work involves nursing knowledge, physical ability, extra time, and hospital equipment, all of which is taken for granted as nurses absorb this into their everyday work. “At the same time, organizational culture exerts a powerful influence over nurses’ work processes, and shapes nurses’ activities around product and productivity” (McGibbon et al., 2010, p. 1368).

Three [complete care patients] is probably the most you would have that would require heavy assistance...to get them walking because they are fresh post-ops...some [require] more than others. (PI 7)

It’s usually heavy all around but sometimes you’ll have a side where you have four or five completes out of six or seven patients. You wouldn’t want to do that too many days in a row ‘cause then you just end up feeling burned out. (PI 5)

[Postoperative patients]... they’re just part of your group...but require constant suctioning. (PI 7)
Seriously ill people they don’t go to ICU...they absolutely have to stay on the floor. (PI 9)

That’s just a reality...people are getting older...therefore lots of elderly people are in the hospital. (PI 1)

We have much sicker patients then we used to....maybe we’re not used to it yet. (PI 4)

It’s a mix of heavy patients, meds, v/s and then all the stuff in between tests, rounds. You gotta get it done. (PI 3)

You know you take care of a fresh post op with an epidural that’s not having any problems...just the monitoring alone is hourly and you mix that with...say you’ve got three or four...two or three ago we had monitoring and we just about cried running the boluses, it’s the normal saline, pentaspan, blood...one nurse has to do all that stuff and you still have your ten patients. (PI 7)

Patients are way more sicker, way more acute than they used to be. You would have an appendectomy done and you’d be in like the hospital for a week straight like years ago, now sometimes you’re just in overnight and you get sent home or lots of patients with co-morbidity, like their hearts and that kind of stuff that needs to be taken care of, or complications that arise post op after they’ve had the surgery and stuff. (PI 1)

We have a protocol for bariatric patients but it takes some organizing. (PI 13)

We have a lot of big bleeds and MIs...or just going bad post-op ...which happens because now they operate on the 85-year-old lady, in the past they probably never would have done, and they aren’t medically fit to start out with, and she gets her gall bladder out and everything goes to hell in a handbasket when they get to the ward. Codes...there is lot more of that...not there should be a cut-off age but lots gets by...she’s a COPDer, emphysema, diabetic ...in the past she would have never been fit for surgery, they wouldn’t have done it... they would have treated but not cut her open, but now they do it ...and let it play out and see what happens, play it out...we have to deal with whatever is afterwards ...which is pretty tough for them...older people...it’s not, just not nice standards for patients...and lots of complications. (PI 6)

People are sicker. We are dealing with more, and more people are more acute, people are older, they are multi-system, ummm, there is so much involved in it. (PI 2)
The acuity level has definitely increased, we’re getting patients that should be in ICU so they’re on the floor and people coming out of ICU, then they have to pick the best one that comes out and if they aren’t supposed to be coming quite yet, but they have to, it’s difficult, because they are coming to a wing where there’s nine other sick patients so they’ve gone from one to one nursing to one to 9 to 10 and families get angry, we try to do our best. (PI 4)

Teams are assigned to 8 to 10 patients; however, as one nurse stated “Sometimes you have hallway patients so you have up to 11, too.” The number of patients assigned to the team does not reflect the actual work that is required by the nurses. “Workload is thus a disciplinary tool that controls rationalization of resources (nursing time) which forces nurses into prioritizing patient care based on their assessment of physiological and safety needs and to conform to hierarchies” (Limoges, 2007, p. 194).

Years ago, report took ten minutes now it takes a long time cause everything, I mean everyone, has had a cabbage, just about and an MI and umm I don’t know if we have older patients, we must have older patients definitely and it’s mostly the pace that’s changed there is no down time during the day. (PI 8)

After noting their assignment, the team discusses how they will work together to care for their group of patients. At numerous times throughout their shift, the team updates each other on the progress of the work and what needs to be done and who will do what next. For example, if one member of the team requires assistance with a heavy, sick, or isolated patient, he or she negotiates how this work will be done. Unseen work requires ongoing communication and coordination of time and resources by the team. This “presupposes expenditures of time and effort” (Smith, 1987, p. 169). Teamwork absorbs the unseen work of total care, isolation, and seriously ill patients.

Nurses enact the labour efficiency discourse by working as a team thereby obscuring the actual work of knowledge, skills, time and planning (Smith, 2005). Working as a team is both cost-effective and efficient. “But teamwork discourse is
conveniently used to support efficiency discourse” (Limoges, 2007, p. 102). Nurses are productive and have learned to organize themselves to be efficient in managing the heavy work. Hospital managers have also come to expect higher output (Rankin & Campbell, 2006). “The discourse, as an ongoing historically committed organization of people’s work, is brought into an active relation with others, who are not themselves participants” (Smith, 2005, p. 137). Not only does this ignore the needs of the patients but it also obscures the work of the nurse. A pair of labourers can work faster and more efficiently than one. Teamwork “is done under definite conditions and with whatever means and tools, that they may have to think about” (Smith, 2005, p. 152).

There aren’t enough bodies physically to pick up the stuff because they’re already one person to ten and they can’t pick up your other nine on top of it...so...but they...you know...we try to work together to get through. (PI 6)

The whole team has to come together, all of the nurses on the whole unit...umm...like, for example, on the Tuesday night...we didn’t take our supper break ummm because it happened right after supper, right after the first group came back and so umm...you’re busy trying to help out with the rest of the unit and sometimes umm you’re trying to and depending who’s on that team...they may have more experience and go help out and then you lose your partner so you’re really, you’re trying to come together to make sure the whole unit is being taken care of because when you have two people, and usually the charge nurse is incredibly busy, too...you have two people busy with that and then oftentimes someone has to take the phone because the charge nurse...she’s busy in there so you’re basically just trying to make sure that everyone is being looked after. (PI 11)

[The dressing]... it took two people an hour from start to finish...because it involves a limb number one and you cannot rush this woman and you know you need the extra set of hands. (PI 7)

You really have to sharpen up your organizing skills and work when your partner is there...because a lot of the day you’re working alone...trying to get a person out of bed is easier with two people. (PI 10)
Only one of our teams doesn’t have isolation...so that has just become part of your day...oh yeh...definitely, yeh...that is normal, gowning...it takes a lot of time so you have to plan around it. (PI 3)

Ruled to care for the generic patient, nurses enact the generic-patient discourse and support the efficiency ideology by working as a team to manage the actual work. The generic-patient discourse is also obvious when nurses discuss that they have increasingly had to incorporate additional services on their units. This means they have to care for a diverse mix of patients under various physician services. Examples include, but are not limited to, general medicine, general surgery, orthopedic, cardiac, respiratory and gastrointestinal services.

If I’ve got fully seven confused complete people that’s really gonna make a difference in the way your day plays out. Or, you can have one really acute patient and that is where your focus is all day...it doesn’t matter if I only had that one patient...I’d be busy with that one patient. (PI 5)

Nurses have no say in which services are part of the unit and explain they are notified by a memo or by the manager when a new service is added. Nurses also say that most of the time they are not provided with the knowledge needed to care for the patient. One nurse explained that she and her colleagues often arrive on the unit without any knowledge about the new patients so either they call their educator or try to figure it out.

We had no in-service on him whatsoever...they just had one in the OR now and one of our educators went down to the in-service in the morning because we can’t go down at 8 for an in-service in the morning...but he takes care of his patients...they’re usually in overnight but still...but that’s a whole other ball game learning about them. (PI 7)

Regardless of the knowledge and additional work required; it is taken for granted that nurses will assimilate the new services into their work to meet the needs of physicians and the hospital. Another nurse said, “No one considers the work that it takes to learn a new service, time, we are expected to care for a variety of patients for the new
services.” Because all patients are constructed as the same, it is assumed that nurses can care for any patient. “Units that are different in terms of patient population and patient needs are grouped together and expected to hold to the same standards” (Varcoe & Rodney, 2009, p. 131).

The Work of Hallway Patients

Overcapacity and overcensus are terms that hospital managers use to describe times when there are more patients than available beds. This means that nurses admit patients to a makeshift room in the hallway which consists of a bed, an overbed table, a silver bell, and a bed with curtains around it. Most hospital units have two hallway rooms that are occupied most of the time.

Every ward, we have to accommodate for the overflow...so every ward has the two hallway beds...it sounds like it’s sticking around...so that must be staying now...it makes it difficult, especially for the nurses who are doing the hands on...taking care of the patients...because you have 11 patients...only one extra but it’s hard to get organized when you have that one extra...especially if they’re all really acute sick patients...and you, then, you know...nobody wants to be in the hall...so then you have to try to get them out of the hall as soon as possible...it depends on people going home...it’s supposed to be that the first person going home...it’s the first option...to get that person into a room...they should be going into a room...but umm...if we’re full, then...DAS...they can’t go in the hall...so often that person stays in the hall...the person who’s just had surgery is going into the room...I always feel bad...’cause I wouldn’t want to be in the hallway...it wouldn’t be any fun...and it’s loud, bright...I don’t think it would be nice...I guess that’s the reality now. (PI 4)

We are at 113% occupancy today...we have 177 patients out of our 156 beds...that means the rest are either waiting or are in the hallway. (PI 14)

The hallway patients... they were only supposed to be I believe, for overload and are happening more often and umm it’s not, it’s not so hard to have them...say...if you’re moving a patient out of a comfortable bed into the hallway, you’re not only dealing with them trying to get them to understand why it’s happening but it takes a lot of your day or they refuse. (PI 12)
When you have two extra patients…but I think just like everything else you know, we get used to it you know, and it’s part of life and it’s what…it’s the new norm. (PI 11)

Increasingly we go through spurts where we have hallway beds and then we don’t have any for a while and for a while it almost sounded like it was going to be taken-for-granted from bedline that it would be easy to use a hallway bed whereas it isn’t …we had a patient who had surgery that day and could have gone home that evening but her ride wasn’t there until the next morning and she was a fresh op so they kept her and in the middle of the night they said to her, you know, we have to move you to the hallway…they thought she would be good because she was going home the next day but once she got to the hallway she cried the rest of the night until she went home at 7 in the morning …so …that was really not very fair to anyone. (PI 11)

Overcrowding has become a daily occurrence and hallway nursing, the norm. Hospitals have even created policies to normalize the practice. A manager states, “Hospitals were designed for an occupancy rate of 85% however most days they run at approximately 115%.” Nurses follow the hallway bed protocol which prescribes specific tasks when admitting an overcensus patient (see Appendix H). This work requires a review of “inpatients who may be appropriate/willing to move to hallway/lounge area” and to “provide patient/family with information & reassurance; reinforce that they will be moved to a room as soon as possible.” Admitting a hallway patient involves coordinating others and their work, for example, contacting the service aide to retrieve an overcensus bed and notifying the utilization coordinator whose role it is to “maximize bed utilization initiatives.” Ruled to follow the protocol, much of the nurses’ work becomes invisible.

I would have to have a bed brought up…well…I would see if they [the patient] was hallway appropriate…which…we’ll usually say…and they have oxygen? That’s a big thing. Can they walk? Or would they use a bedpan? They can use a bedpan in the hallway and if they can walk, there’s usually a bathroom close by that they can use. (PI 5)
Because of the hospital’s overcapacity issues, nurses are required to absorb another patient into their work. “What is observable does not appear as the work of individuals, and not all the work and practices of individuals become observable” (Smith, 1987, p. 162). Taken for granted as part of nurse’s work, the creation of the hallway work process, overcapacity, is normal in acute care.

It adds extra work for the nurse...on that team...those teams umm...and it’s difficult to nurse people in the hallway because how they are situated, as you saw, even just the geographic part of it...the one is right as you come on to the unit and if it’s a patient that you have to boost or turn or whatever...you can’t get to the other side of the bed without...you know what I mean...’cause they can’t sit in the middle of the hallway and you can’t get around the bed umm...but, like, it would be mostly frustrating for the patient. They don’t have their own bathroom, they have no privacy...hipa would be a huge thing there...if you were concerned about what the doctor is telling you in the hallway and people are walking by...and even though there’s curtains there, come on, those curtains don’t stay shut all the time...people looking at you...I think it’s terrible. (PI 4)

You already have a full load and then to add to your full load ...you have...you only have so much time in a day...and it has to be organized accordingly...and if you have a hallway patient it leaves less time for everybody else...and you know...it stretches...it really stretches your nursing capabilities and really increases your stress levels...I think that hallway nursing is really awful...those rooms are awful enough but a hallway...a patient in the hallway is just despicable...I really don’t like it at all...they never sleep...I think that it decreases all around the care...I think it’s awful...and it sure changes your day as well. (PI 6)

It’s difficult to nurse people in the hallway because how they are situated as you saw even just the geographic part of it...the one is right as you come on to the unit and if it’s a patient that you have to boost or turn or whatever, you can’t get to the other side of the bed without...you know what I mean? Cause they can’t sit in the middle of the hallway and you can’t get around the bed...but umm like it would be frustrating for the patient, they don’t have a their own bathroom, they have no privacy. I think it’s terrible. (PI 13)

Hallway beds, yeh...they add to your patient load...I find hallway beds very very frustrating because they ...you feel bad for them and their families...like who wants to be stuck in the hallway? And not all the time are they hallway appropriate is the other thing...like the other day we got one who needed
oxygen, the other night when I worked nights and he ran out of oxygen on our tank...and we walked by...and we couldn’t figure out why he was grunting...he couldn’t breathe...he ran out of oxygen...I find that very very frustrating and having to do pure oxygen ...having to do nebs on pure oxygen and I...you have to find them a bathroom...to give them a bathroom who is the same sex...trying to find a man’s room so he can go to the toilet and the family can’t sit there and visit with them with the bed in the hallway. (PI 3)

Nurses repeatedly express concerns for patients’ privacy and their care in the hallway. Nurses are expected to make adjustments in their work to accommodate hallway patients. For example, during my observations, a patient in a hallway bed needed to go to the bathroom. This meant ringing the silver bell, usually a couple of times because the nurse was not in close hearing range, which was followed by the nurse checking to see if another patient’s bathroom was vacant and appropriate to use. On another occasion, the visitor of a hallway patient asked for a chair. Because chairs are not part of a hallway room set-up, the nurse had to search multiple rooms. This taken-for-granted work suppresses “the presence and working of the underlying relations they express” (Smith, 1990a, p. 37). Ruled by unseen power to absorb hallway patients into their work, nurses participate in the institutional discourse and are shaped to follow protocols that compromise them, their patients, and the hospital.

The patient first versus the no bed challenge because if you have no beds...you can’t put the patient first...but if you have the patient you can’t put ‘em first because someone else might need the bed. (PI 2)

The Work of Saving Money

Nurses have long been the brunt of management practices to facilitate hospitals’ cost constraints and this strategy continues to impact nurses’ work. One day after the provincial government announced the annual budget, a memorandum from the President and Chief Executive Officer, Dwight Nelson, addressed to all staff, stated “RQHR has
been tasked with reducing operating costs through efficiencies by $11 million, of which over $5 million must come through the reduction of wage driven premium (WDP) hours” (see Appendix I). The government also sees controlling wage-driven premiums as a way for health regions to contain costs (Government of Saskatchewan, 2010a) Wage-driven premiums equate to two times the regular rate of pay for nurses and are paid to nurses who work overtime hours. Nurses are subject to mandatory overtime as a way to fill vacancies.

The directive from the CEO of SAHO says we don’t replace the first sick call...I think under extenuating circumstances depending on the needs of your unit you can replace someone at straight time but if it’s overtime you wouldn’t be replacing for them. (PI 5)

You can’t replace at straight time...so that’s probably going to be overtime and it might well incur premium pay...because it’s a night shift and it goes into Saturday...so you really can’t get out of here until you get that sorted out .(PI 4)

When you start paying out premium and overtime, you’re in big trouble in a big hurry. It’s all about the bottom line. (PI 14)

Now we’re over budget quite a bit and the government is more stringent with finances and stuff. (PI 15)

The interview transcripts reveal how managers are socially organized to enact cost-containment strategies. Ironically, the patients and nurses disappear in the cost-saving discourse. By following the CEO’s directive on reducing operating costs, managers are ruled to maintain the government’s budget shortfall. They are told they will have to reduce wage-driven premiums because they impact the hospital’s operating budget. Shaped by the government priority to target nurses who are paid premiums, managers establish protocols for nurses and control increasing labour costs.

Because of the overreliance of overtime; hospital labour costs are blamed on nurses and contribute to the number of nurses’ sick days. The reliance on overtime has
resulted in high labour costs while the sick-days coverage is symptomatic of the low regard for nurses’ labour. These high labour costs are a symptom of the problem and not its cause. In blaming “nurses’ high wages,” they are victimized for the failures of the system that are making them ill. Governments and hospital administrators perceive this to be a hospital’s single greatest expense that is believed to be driving health-care costs even higher. The memorandum describes these costs as being associated with “replacement for an exceptionally high incidence of sick time and time lost to injury” and “replacement for absence due to vacation and other leaves” (D. Nelson, personal communication, May 25, 2010). As a result, managers made a decision not to replace the first nurse who calls in sick, unless the unit was ‘really heavy’ leaving the staff to work with one less nurse. “Because nursing costs are significant, nurse staffing is subsequently targeted as a potential source of cost savings when hospitals are faced with economic and market pressures” (Pappas, 2008, p. 230).

We’re very much directed to control overtime...the biggest place that people run into trouble is staffing...you know when you start paying out premium and overtime you’re in big trouble in a big hurry. (PI 14)

Yes, that again, she will say we have one sick call, we have two sick calls, and then it’s my responsibility to look at the patient assignment to adjust, to lump, to put two teams together to make one big team or divide the unit in half, adjust the break. (PI 1)

We were told we can’t replace first sick calls unless it’s absolutely necessary. (PI 12)

If I was charge I would have to find a replacement...usually depending on what time of day you get the sick call, it’s charge’s job to phone the scheduler and find a replacement...but the scheduler will often ask you, Do you want to replace with overtime? and you kind of have to make some judgement calls there and depending on how sick the patients are and if you think that another staff coming in on overtime is really needed then...you have to make that call if the
manager isn’t around...and I know...I know more or less what my manager would want me to do. (PI 10)

The nurses’ comments demonstrate their role in the exchange of labour and economic resources. In times of reduced government funding, nurses are regarded as a commodity, dependent on the hospital’s priorities. Coordination of ruling is achieved by connecting nurses’ salaries to the hospital’s escalating costs. As the largest budget item, nurses are disposable labour, at the mercy of the administrator’s decisions. “Because they are removed from the process of patient care, administrators are more likely to perceive nursing activity as routine and accordingly staff the hospital to minimize cost” (Bloom, Alexander, & Nuchols, 1992, p. 1414). Within the hierarchy, managers are organized to control labour costs “and treat” nurses “as resources to be managed” (Rankin & Campbell, 2006, p. 110).

Well, they are trying not to use overtime. I mean, if we need overtime it’s allowed...some places they said it wouldn’t be allowed but they have paid us overtime if I stay late or if something is needed we’ve had it but it’s not ummm...you know, the pendulum is pretty much swinging back the other way now because for a while you wanted it, you got it ‘cause they had money and now if it’s absolutely necessary we will try and get it. (PI 7)

Most of my charge nurses now are better about thinking of premiums...some used to say...fill the shift at any cost ...and you can’t do that ...we just can’t do that...and it’s interesting because we’ve probably had less sick time because we don’t fill shifts...umm...but you need to make a plan and sometimes it’s just a contingency plan because you’re not going to fill the shift and some people ...depending on who’s here ... are really good at how to distribute the work load. (PI 15)

The hospital and government agenda is to maintain their bottom line and have obedient nurses provide for the patients. It is assumed that nurses will work with inadequate staffing, save the institution money, and still deliver safe patient care. These
decisions continue to reinforce the power within the patriarchal structure while shaping nurses to adapt their work practices.

Nurses have historically been targeted when hospitals need to cut costs and sadly they have come to expect that as normal practice. Nurses have learned from past experience to “work in terms of cost efficiency, learning how to make...decisions that are coordinated in relation to the hospital’s budget” (Campbell, 2006, p. 103). Nurses are considered expendable and are an easy target when it comes to cost-containment strategies. Nurses absorb the emotion that goes with working short-staffed. When the hospital professes to adhere to the Patient’s First discourse, nurses inevitably come last. The provincial budget dictates that nurses be considered a commodity. Saving money to meet the government’s budget shortfall matters more than quality patient care.

Besides the pressure to meet the budget fallout, nurses are also tasked with deciding if there needs to be a staff replacement. “The accounting logic of the concept as it now circulates in the discourse dominates their thinking and influences how they act” (Rankin & Campbell, 2006, p. 149). From their place of power, managers leave nurses in the position of making such decisions to support either their colleagues or the hospital’s budget directive. Inevitably, nurses are faced with negotiating among themselves, patients, and colleagues, while obeying the hospital agenda. The work of managing the budget has become an invisible part of nurses’ work. Nurses follow hospital directives for fear of making an inappropriate decision. “These are distinctive contemporary forms of social organization which intersect with the largely hierarchical structures of state, business, and other administered formal organizations” (Smith 1990b, p. 214). Shaped by the provincial government’s shortfall budget, nurses are required to manage the costs of
their labour. Nurses are ruled to make the budget a priority which minimizes safe, quality care.

Because of the hospital’s invisible, oppressive power, nurses take responsibility for the problem. One nurse stated, “We were spoiled ...it wasn’t budgeted over the last year...we had extra help...and now the budget crunch and you know they’re all talking about saving money...there’s less and less staff.” Nurses have been conditioned by an ideology of scarcity, believing it normal to work with fewer staff and to make do with what they have, when the hospitals cut back on labour resources. It is blatantly evident that nurses are targets for cost-containing measures because they will accept this as part of their work. Nurses are blamed for the hospital’s fiscal woes and are seen as a way to manage costs. This becomes an invisible way of controlling sick time and of reducing overtime costs. “The new social relations that coordinate work practices carry values organized around budget and cost efficiency” (Campbell, 2006, p. 102). It is the managers who rule in making operating costs a priority, it is neither the nurses who do the work nor the patients who receive the care. “A ruling class is the basis of an active process of organization, producing ideologies that serve to organize the class itself and its work of ruling, as well as to order and legitimize its domination” (Smith, 1987, p. 57). Cost is clearly valued by the institution more than the emotional toll that the intensified work takes on the nurses.

The media further fuel the budget discourse; for example, it was reported on November 25, 2010, that

The number of hours worked at "premium" or overtime rates per full-time employee is down 20.1 per cent from a year before, says the health ministry. Sick time is down an average of 4.4 per cent per full-time employee, compared to the first half of 2009. The savings come after health regions were asked to find
"efficiencies" as the Saskatchewan Party government sought to hold the line in the spring budget. (Hall & Cowan, 2010)

Government ruling is a mechanism for controlling nurses’ sick time. Nurses are invisibly blamed for the escalating costs, while management practices are praised in the media.

Such textual surfaces presuppose an organization of power as the concerting of people’s activities and the uses of organization to enforce processes producing a version of the world that is peculiarly one-sided, that is known only from within the modes of ruling, and that defines the objects of its power. (Smith, 1990a, p. 84)

The efficiency discourse intersects with budget measures which has power over nurses’ salaries and controls their sick time. “Creating and reproducing ideology, concepts, knowledge, theory, etc., have been largely the business of an intelligentsia, carried on in multiple sites and a variety of media, but participating in the same, loosely coordinated complex of relations” (Smith, 1999, p. 174).

**Working Short Staffed: Combining Work**

Ruled to meet the hospital’s bottom line, nurses knowingly shape their work accordingly. “Organizations are …social entities, embedded in complex networks of beliefs, cultural schemes and conventions that shape their goals and practices” (Hasselblad & Kallinikos, 2000, p. 698). To manage their workload when a nurse is not replaced, nurses enact the budget discourse and develop a plan to ensure that patient care is met.

Well, there is a contingency plan that is made up by the manager if you are short ummm and the contingency plan is you lump team one and two together. Now you could have, you know, 15 out of 15 acute people there and it wouldn’t matter, that is the team that you lump together. (PI 2)

If we are down by one nurse...if one nurse calls in sick we don't replace the first nurse so then team one and two are split and combined so that there are three
nurses there instead of four and then we divide it up five, five and five and you do everything for your five people. (PI 5)

Cleverly disguised as their problem, the nurses’ comments reveal how such a situation forces them to establish a work process that maintains the staff-shortage discourse. Nurses have learned to “accommodate and advance a hospital’s cost savings” (Rankin & Campbell, 2006, p. 149). Rather than a team of two nurses caring for eight patients, a team of three nurses will care for up to 15 patients. “The discourse is maintained by practices that determine who can participate in it as fully competent members” (Smith, 1987, p. 61). As a way to manage the increased workload, nurses discuss how they make decisions to edit patient care.

Being short is awful, it’s almost like basic care happens as opposed to the best care...if we’re down a nurse in the front side...you just do to get it done and you just do the basics, like clean...you won’t do the little nice things like a tub bath. Those things get missed because you just don’t have the time to do it. (PI 3)

I’m not okay with this patient not getting bathed today...even if we are two nurses short, I’m just not okay with that you know. (PI 12)

You make a decision at that point ...and I tell them, if you’ve got eight completes then you won’t be able to do all the things that you will need to get done. (PI 1)

Hospitals make decisions “based upon economic and political values rather than values reflecting the broader social responsibilities of individuals in the community” (Storch, 1996, p. 25). Nurses have come to accept this as part of their everyday work, while the managerial hierarchy assumes nurses will adapt their work to accommodate understaffing. Nurses absorb the extra work, but understand the impact of their doing so. Ruled by sophisticated forms of economic and patriarchal power, nurses conform to this dominant discourse and perpetuate the selfless ideology legacy.

Working short will change your day...because if you’re the only charge that doubles your workload, shortens your break or eliminates them and umm...and
umm on the ward...you know, there is a certain hysteria that comes ...if the ward is really heavy or if the ward is really critical. (PI 7)

We have been working short for five months...most days you work 1-2 short...why are we always penalized ...we’re burned out and sick time is going up....everyone is stressed and sick all the time. (PI 6)

The very first thing that’s frustrating in the day is not only being short but then the assignment changes cause it has too, right? So, now nights has taped based on a full assignment ...so then the tape recorders have your assignment that you’re used to...well now all of a sudden you picking up another two patients from another team. (PI 5)

These past three days they were short so between three girls, they had thirty some patients or something. You're stressed out all day and you have ten patients to medications too ...instead of eight you know...or whatever is normal. (PI 12)

**Taking Care of the Business: Monday to Friday Work**

The *work* of hospitals is primarily a Monday to Friday, 7 a.m. to 7 p.m. regimen which equates to approximately 36% of the time when nurses have access to the resources and services that support their work (Hamilton et al., 2010). For example, supplies are delivered to the units during business hours; however, should there be a need after business hours, nurses know they will have to wait and make do without or create a process that works around the system. Nurses are coordinated by an ideology of scarcity which relies on nurses’ selflessness and assumes that, regardless of the time of day, they will manage with what they have to do their work. One needs to look no further than to the diagnostic departments, the managers’ offices, the kitchen, the central-supply services, and the hallways, which are almost vacant on weekends, nights, and holidays. Nurses, too, note how the pace of the business is notably different on certain days of the week. To meet the demands of Mondays and Friday, nurses adapt their work and absorb
the business of maintaining the operational hours. Nurses organize their work to meet the hospital and physician’s needs.

*I can’t help but notice the difference on this holiday. Less noise, physicians and staff yet the nurses’ hurried pace isn’t any different. They go about their work and talk about waiting until tomorrow for the return of various services.* (FN 3)

Mondays and Fridays are insane...Mondays you are picking up all of these new patients that you didn’t have...if you were off on the weekend...usually you start back on a Monday and you have all of these new patients and all of these tests that are jammed into Monday...like everything that you can possibly think of they try to get it done...so people that were sitting there over the weekend...waiting for these tests to happen on Monday. (PI 3)

Fridays are tricky because the weekend is coming so you wanna get discharges by Friday so there isn’t a lot of loose ends on the weekends when departments are closed and the other thing is ...umm...a lot of doctors...especially on Friday...leave early so you have to get on things early in the morning because some of them are gone by noon or by 2 o’clock they’ve signed out and if you need things and you are counting on them to be there they might not be...sometimes certain services occasionally don’t have anyone on call for the weekend...plastics or sometimes urology, so you have to make sure things are in place so patients don’t run into trouble. (PI 4)

On weekends there’s one person on call and a lot of departments are closed so you have to make sure on Monday that you pick up the pieces that weren’t able to be done on the weekend ...sometimes it’s just doctor appointments for the patients and the ward clerk helps with that...sometimes it’s ummm...something like a test that was ordered Friday and of course it’s to be done on the Monday so just follow up for that...what else is there...umm...speech language isn’t there every day so that’s another...sometimes it’s equipment things. (PI 1)

During the week it’s always busier because there’s five days or four days that stuff can get done and everything crammed into those four, five days...you know if it was 24/7 ...the hospitalist thing...the 24/7 there...should be certain disciplines that should be here...pharmacy is one there...24/7 ...and I do think that some diagnostics could be done in the evening. (PI 2)

Mondays are usually crazy...umm...because especially if it’s after a long weekend...but just Mondays in general ...um...because doctors haven’t been around...physio hasn’t been around...umm...the weekends are generally quiet because you don’t have all that going on ...and on Mondays the doctors come in and see what’s been going on over the weekend and then all of sudden you have
a thousand new orders that you have to try and umm...to get through that day. (Pl 11)

Mondays are harder because you don’t know the people like you did on Friday so there is new people and more to get up to speed and plus on weekends there’s one person on call and a lot of departments are closed so you have to make sure on Monday that you pick up the pieces that weren’t able to be done on the weekend. (Pl 6)

It’s Friday at noon and doctor wants an ultrasound done, a doppler of the leg done because we think there could be a DVT. How do you get that done when ultrasound closes at 4 o’clock? You know it’s noon on Friday and you know you’re not gonna get it done til Monday so you know that that is a lot of work, that’s a lot of work... you’re trying to do this, you’re trying to do that, everything else is put on hold because you know that is priority right now that’s come up and that’s priority ummm trying to get a hold of physicians and they might not call you back and they might not call you back, pause. (Pl 1)

So ...it seems that everyone goes for tests on Mondays (laughs)...they’ve been waiting...especially if they’ve been admitted on a Saturday or something...they wouldn’t have got a CT or a chest x-ray unless there was an emergency...so everything seems to be done on Mondays. (Pl 12)

Friday is crazy ...we are always checking about tests, making sure they are done or on Monday, the doctor will yell at us...because the test wasn’t done...that’s why I ordered that bloodwork stat...get the results quicker...it’s all a game and you have to know how to play it. (Pl 9)

Monday and Fridays are the busiest ...Fridays just because you’re trying to get everything done before the weekends come...it’s all about weekends I guess.” “We don’t seem to control of...is our own time...because most places have rules...physio says I can only see so many patients today. (Pl 4)

This harkens back to early days when, to meet the needs of the hospital patriarchy, nurses adapted their work to maintain others’ agendas. Ruling hierarchal relations are central to how nurses talk about their work. “The fact that this is primarily women’s work has important implications for the structure of the work and the value added to it” (Armstrong et al., 2008, p. 87). Hidden power relations dictate that nurses keep up with the Monday-to-Friday regimen. This means that they follow the Monday-to-
Friday operation without question, subsuming the work required to operationalize the
business of the hospital. “What is required is that the nurse acts in a reliable and
disciplined way, if not carrying out explicit orders, then following set routines” (Davies,
1995, p. 95). Though integral to maintaining this operation, nurses work in ways that
assist in supporting the Monday-to-Friday establishment. Unseen power relations
organize nurses to enact work processes to manage the work of Mondays to Fridays.

Nurses provide their services 24 hours a day, 7 days a week, while services
provided by pharmacists, dieticians, physiotherapists, social workers and managers
follow business hours and are available primarily weekdays, during the day.
Undoubtedly, patients require other services during the evening, night, and weekend
shifts but, because the hospital runs like a Monday-to-Friday business, services and
resources are often unavailable or are cut back during those hours. Nurses are considered
essential to the care of patients in hospitals yet, oddly, the majority of the time, they are
expected to work unsupported and to absorb the work of others who leave at 5:00 p.m.
“The boundaries remain porous not only because the nurses are always there, but also
because the work must be done” (Armstrong et al., 2008, p. 86).

Since early days, nurses have worked with limited resources in providing patient
care around the clock; this fact continues to rule their work today. Ruled by the inherent
hierarchy and a history of domesticity, nurses’ place in the hospital is clearly to serve and
obey, regardless of the conditions or the support required. Sadly, nursing remains situated
in a structure that does not value feminist ideologies such as caring (Boychuk Duchscher
& Cowin, 2006). Furthermore, because most others are not present after business hours,
there are few who actually see nurses and their real work. Therefore, for the majority of time, nurses’ work is invisible.

Shaped by a history of scarcity and a serving ideology, nurses have come to expect that this is how their work environment functions. By comparison, pharmacists work 7 days a week; however, only until the early evening. Should nurses require medication(s) after the pharmacist leaves for the day, they have to call the security department and ask the security guard to go into the ‘night cupboard’ to retrieve the medication. Hospital problems have become an inherent part of nurses’ work; many of them are situated outside the work of caring for patients. Obedient nurses have the knowledge to give medications to patients, yet ironically, during evening and night hours they require a person who is not directly involved in patient care to retrieve the medications.

Because of the movement of patients within the hospital, missing medications is frequent problem for nurses. During the day, missing medications is a common occurrence that results in nurses having to fax or call the pharmacy department and request the medication. Pharmacists do not routinely deliver medications unless they are going to be making a trip to the unit. Thus, nurses have to wait for the medication(s) to arrive by a porter who comes by the unit every hour, since the pharmacy is located in another part of the hospital to which nurses do not have access. To manage missing medications and accommodate a reduction of services nurses have learned to work around a system that doesn’t support their work. For instance, knowing that medications are frequently missing and that it takes time and effort to obtain them, nurses have resorted to saving unused medications from the medication drawers of patients who have
been discharged. Nurses share with other nurses where the “stash” of medications is located; however, they keep this secret from the manager and the pharmacist since they know that the medications will be taken away if they are found. Because nurses are ruled by the pharmacy’s medication time schedule, they create a process which ensures the patients will obtain their medications according to the hospital’s regime.

Missing meds...that’s a constant...every day...pharmacy is short-staffed...they'll tell you that...so it’s technicians that load, not that they’re unknowledgeable but they’re probably rushed and they’re not the pharmacy ...I would be missing something...if somebody is admitted on nights...even if it was faxed...you won’t get those meds in the morning...and it may...they’re supposed to deliver hourly...sometimes it’s two to three hours...or it’s just totally missed...not put in by the pharmacist...I think she was having problems but anyway...you know, three, four meds that she forgot to put in ...to tell the technicians that it has to be sent up to the floor...missing meds is a pretty common fact of life...every day...you phone...and then it will come up on rounds...unless it’s a stat...it’s time consuming. (PI 7)

It’s quite common to phone for several meds each time you have to give them...it takes a lot of your time really and then you have to wait...and then...for example, if it’s antibiotics that was supposed to be given IV and you give it an hour later, well, then that affects other medications because you should probably try to keep them eight hours apart or whatever or whatever it happens to be, 12 hours, that affects the other medication time too. (PI 5)

I’ve waited for two hours for a medication...it depends on what time you call because they do...like they bring...medications up or whatever every two hours I think it is or so...so...I think it is every two hours...so if you happen to phone, you know ...right before oh...sorry, right after that two hours then you kind of have bad timing...(laughs)...you have to wait for the other one. (PI 12)

Waiting for these medications to come up and really, they’ve actually, they’ve put them where ...in the fridge...where they’re supposed to go because pharmacy actually brought them up on their round to stock all the medications for the next 24 hours. (PI 3)

During the time of the observations, two memorandums provided evidence in tracing the institutional discourse: “short facecloths; no linen delivered on a stat holiday” (FN 5). Nurses described this as common on weekends and holidays and resort
to taking linen from other units and using disposable facecloths; some nurses discussed ripping towels in half so that they could wash patients. Although nurses discuss being short of supplies on a regular basis they explain that they find ways to work around the system. “We are often missing cups…so we stash them because we need them for Metamucil.” Hoarding and taking supplies from other units are common practices to deal with such shortages. A memo from the Ostomy and Wound Department reads, “Due to the unforeseen staffing issues we will be unable to provide the levels of service over the next month” (FN 10) which actually means nurses are expected to absorb the work of the Ostomy and Wound Department into their day. Taken-for-granted as just part of nurses’ work, other services know that nurses will do their work. Organized in a hierarchy that keeps them subservient, nurses absorb others’ work into their work. Nurses accept this work as a normal part of their work.

Several boxes sit in the hallway and the manager explains that the boxes contain bedpan flushers that will not be installed for three months because it’s not a priority. This means that nurses will have to make do with using the archaic bathroom sprayers and wear protective equipment to avoid being sprayed. It is assumed nurses will work in any condition and that their health and safety are not important. Nurses are expected to manage with what they have or have not got; after all they have been able to work like this for many years so why would things be any different today? Because nurses are the closest to the patients, it is assumed they will take up others’ work in order to meet the patients’ needs. Regardless, nurses remain unsupported the majority of the time figuring out a way to cope with the next problem. Sadly, nurses reinforce this discourse by taking
responsibility and integrating systemic issues into their work, believing it is part of their work; this ultimately takes the focus off the hospital’s problems.

Much of nurses’ work is organized around the work of others in the hospital. The social order of nurses was repeatedly evident during my observations. Phlebotomists, pharmacists, dietary staff and physiotherapists were often noted to interrupt nurses during their work to obtain information about patients. Routinely nurses will consult them for specific patient needs. For example, should a patient need mobilizing, nurses will consult the physiotherapist. One morning, a physiotherapist was on the unit and explained to a nurse that because of his increased workload, the patient’s physiotherapy session would be cancelled and the nurse would have to find the time to mobilize the patient. Other services can place limitations and control their workload, however, regardless of the nurses’ workload they are still expected to continually absorb the work of others despite the fact that it adds to their work. Nurses consider other departments off loading of their work as normal practice. “When such work is not done by others in a timely and efficient fashion, nurses must do it precisely because it is essential to care” (Armstrong et al., 2008, p. 86). Rooted in selfless ideology, nurses accept other’s work is their work.

Within the hospital, nurses’ time is understood to be less important. For example, the multidisciplinary discharge patient rounds occur in the middle of the morning, an especially busy time for nurses. Since discharge is a priority, these obedient women stop their work, enter the meeting, provide information about what they know about the patients, answer questions from the group and then leave the meeting and return to their work. Since they have 24 hours, they assumingly have all the time in world as long as everyone else gets their work done first. “The work that women do, after all, is noticed
when it is not there, and taken for granted when it is” (Davies, 1995, p. 165). Nurses remain handmaidens serving everyone’s needs while largely ignoring their own.

Nurses frequently wait for the work of others in order to get their work completed; they have come to expect that they will have to wait on others’ work in doing their work. Every day, nurses wait for medications, beds to be cleaned, patient consultations, calls to be returned from physicians and other services. It is apparently assumed that their time is not important and they can expect to wait. Through historical relations, nurses are understood as integral to the function of the hospital yet remain a low priority within the hospital hierarchy. This place is part of the discursive organized relations of hospitals. “From the traditional sites of women’s work and consciousness, orientated towards particular others and situated in local contexts of action, the ruling relations and apparatuses appear as abstracted systems, translating local events into the extra-local organizational forms of ruling” (Smith, 1989, p. 42).

You have to wait for the consults...they sometimes take a while. ...so it’s like multisystem and there’s always other factors that come into play. (PI 4)

You’re waiting all day to transfer...to admit...waiting for beds to be cleaned... the big thing is usually waiting for phone calls...you put out phone calls to the doctors, often times they don’t get back to you so you’re waiting for them to call back as well ...so usually I have a few calls out at a time ...waiting for the docs to call back...some call back soon but there are some that will take a long time to call back. (PI 10)

If other departments are working short that also impacts our day tremendously... if physio is short it’s harder on the ward ...it’s harder to get people out ...and everything takes longer for discharge... if there’s no speech language and you need one...that’s a tremendous problem... diabetic educator, if they’re sick they’re not always replaced and so most of that can wait...but it’s telling the doctor, No that hasn’t been done yet. (PI 7)

We’re talking to the physio satellite to make sure of what time is their physio time, because we have to have them up in the chair and medicated with pain
meds prior to going...we usually phone them...and if we don’t phone them, then they just show up to get the patient for physio and then we...they’re mad if they’re not up in the chair with pants on and have medications half an hour prior. (PI 6)

I do have to do that, I need to do that, I need to phone MRI, phone ultrasound, phone CT and say, No we can’t wait for two days, we can’t wait until tomorrow, we need to have that done today. So...you know, if you can plead your case, so sometimes that is what you have to do, is plead your case. (PI 1)

Similar to early days, nurses work in an oppressive system and attend to keeping the order of the hospital status quo. “Objectified bodies of knowledge embedded in discursive organization are known by the members of the relevant discourse; through processes of controlled training, those members bear a body of knowledge externalized in texts; they become its knowers” (Smith, 1990a, p. 84). “Bureaucracy’s...tendency seemingly to forget its own missions, its lack of regard for persons, can all be understood in terms of the partial project of masculinity with which it is associated” (Davies, 1995, p. 56). Much of nurses’ work remains buried within the ruling patriarchal hierarchy, which continues to serve the needs and hours of physicians, administrators and other hospital personnel. Nurses have learned to work in a system that is open for business 24 hours and places their work last. Without knowing, nurses engage in managing the business and reinforcing the power of the operation. Ideals of sacrifice and obedience are “sustained by patriarchal and organizational discourses which have permeated the way in which nursing practice is configured” (Cheek, 1995, p. 237).

Get ‘em In and Get ‘em Out (Quickly): The Work of the Efficient Discharge

The business of the hospital requires the flow of admitting and discharging patients, however, overcapacity and overcrowding have become synonymous discourses within hospitals today. “Conditions become conditions only in the context of a practice
and are themselves the product of practical activities. The ideas, concepts and categories in which the ordering of people’s activities becomes observable to us are embedded in and express social relations” (Smith, 1990a, p. 38). Because of these conditions, discharge processes have become a priority for hospitals and are “linked through particular institutional relations” (Griffith & Smith, 2005, p. 34). This discourse is evident in how nurses discuss the importance of discharging patients.

It’s totally discharge driven, really nothing else. (PI 9)

Well it’s all about discharging them home, the main thing when they come in is always working towards discharge. (PI 8)

They discharge people so fast and so you’ve got to be ready...you have to be alert to which ones are going home to get them [the patients] home fast so the beds can be ready. (PI 4)

Discharging is the most important ...getting them out...physicians discharge their patients sooner. (PI 14)

Sometime the patient’s not even gone in the room and they’re going into, emerg will be phoning up to give us report and we’re sitting here saying our patient’s not even gone, the bed’s not even clean or anything. (PI 2)

Everything is about pushing....they always want us to move quicker. (PI 5)

We don’t even have enough beds...and you know you can get a discharge and the room can be cleaned and you can have an admission 15 minutes later...that’s just a reality...people are getting older...therefore lots of elderly people are in the hospital and that’s the reality and I know that will never change unless...well it’s never going to change. (PI 2)

The admission, discharges...have probably tripled like on a day-to-day basis. (PI 4)

To address the increasing public and government pressure to reduce wait lists and overcrowding, hospitals have adopted lean programs that increase efficiency and expedite discharge. Lean is touted by President and Chief Executive Officer (CEO) Dwight Nelson
as “a patient-centered approach to our system with the benefits of reducing waste and
building strong and reliable processes.” (Lean on me, 2010). Since lean practices focus
on efficiency, assigning targeted discharge dates (TDD) to each patient is a strategy to
move patients out of acute care (ironically, a strategy implemented in the 1990’s that
failed). Once the date has been determined, the multidisciplinary health care team works
toward an efficient discharge plan focusing on discharging the patient on or before the
TDD. This actually means moving patients through the system as quickly as possible so
that the next patient can be admitted or transferred from another unit.

You know if you send four people home and you have four people coming back
in, you’ve turned around eight people in sometimes three or four hours and that
is a phenomenal, that is phenomenal to do that, tell me about phenomenal, like,
ummm, well, just start with the ward clerk, for example, she’s not only doing all
of the admissions, she’s doing discharges and the paperwork to do that is
tremendous, the nurse not only has to discharge the patient but try to do patient
teaching, make sure that everything is in order for them to go home and then
they have to change gears and they gotta bring a new person in, all the
assessments ,all of the paperwork, they say to do a good admission takes over an
hour. (PI 7)

Thus, “the managerial goal of efficient discharge is also enlarging, and
specifically shaping, nurses’ sphere of attention and activity” (Rankin & Campbell, 2006,
p. 145). Nurses integrate these terms into their work

Without realizing the source and the efficacy of meaning they carry with them
into the settings of their use; they become an active currency of ruling, operating
in the interests of those who set them afloat and may have designed them, but
their provenance and ideological ‘intention’ is not apparent in them. (Smith, 1999,
p. 176)

Throughout their shift, nurses activate the discharge discourse. From the
beginning of the day, during shift report, each patient’s discharge needs and potential
discharge date are discussed. “To teach nurses their ‘new’ knowledge, and to ensure that
nurses participate competently in activities that allow various new institutional
maneuvers to be made, additional managerial and professional strategies have had to be devised” (Rankin & Campbell, 2006, p. 88). Upon entering a patient’s room, nurses write the targeted date of discharge on the whiteboard mounted on the wall, which allows the patient to see the date. Since nurses are the closest with the patient, they are often interrupted by pharmacists, social workers, physicians, dieticians and physiotherapists to provide information about the patient’s progress related to the discharge plan. They are asked questions about the patient’s mobility, breathing, pain, blood work, intake and output; they are also asked to provide information to the patient and give messages to the family. Apparently, it would seem that nurses are the valuable when others require information or need to communicate messages to patients.

Monday to Friday, nurses stop their work midmorning to provide information about their assigned patient to the multidisciplinary team. The team discusses the plan to facilitate discharge. For example, if the patient needs oxygen, home care or other services upon discharge, the charge nurse will make a note to obtain an order from the physician. Nurses have the knowledge and skills to meet the patient’s targeted discharge date. If the patient requires increased mobility, more fluids, or oxygen weaning, the nurse will plan accordingly during her shift. The pressure to work towards efficient discharge has increasingly become the nurse’s problem.

Bedline, a service located outside of the hospital, facilitates admissions, transfers and discharges. Personnel from Bedline call charge nurses several times during their shift to enquire about bed availability and to provide information on patients who are waiting for admission. Several nurses commented on the incessant phone calls stating, “It’s frustrating because they are always calling” (FN 17).
They usually call a few times to see if that bed empty yet? (PI 4)

You’re having a busy day and one of your patients gets discharged or worse off...one of your patient dies and you already have...and it doesn’t seem like you can barely get over that and you have bedline calling...I have another admission for you...that can be difficult. (PI 11)

In preparing for discharge, nurses must know the patient’s mobility level, diet, medications, bowel and bladder habits. Upon receiving a discharge order, the unit clerk enters into the computer system that a bed has become available. While the computer screen may show that a patient is discharged, much of the actual work of discharge is not seen and goes unnoticed. The work of discharge requires understanding the patient’s needs once he or she is discharged.

They also arrange future appointments with physicians and other services, provide patient education, complete the required computer and paper work, and call other services if further information is needed. Then they wait for families or friends to pick up the patient. Nurses will often assist patients in packing up their belongings, locate a wheelchair and then accompany patients to the door. Nurses can also be seen saying good-bye, giving hugs and offering reassurances to their patients. Besides having the knowledge and skills to “get patients out” quickly, they also know how to be efficient in facilitating the next patient admission. After each discharge, housekeeping cleans the room as part of preparing for the next admission. Knowing this, one nurse stated, “Sometimes you have to give them a little nudge that you need the bed [cleaned].” Efficiency ideology dominates nurses in their work actions as they participate in activating the discharge discourse. “Methods of discourse in which we participate as intellectuals constitute objectified standpoints” (Smith, 1999, p. 74).
Nurses are integral in facilitating patients through the system. They know who to call, what services are required and what is needed to speed up the discharge process. Nurses’ “knowledge of the social world is situated in time and space, constructed by particular people in particular places and reflecting the interests of those who make it” (Griffith, 1998, p. 369). They also have knowledge about what services, such as home care, the patient will require upon discharge. Nurses understand that controlling pain and mobilizing patients will expedite a discharge.

We have to get the patient off the morphine as soon as possible so they can take oral meds and go home quicker. (PI 7)

If they are brand new and they are acute, then we say they are acute, but if you realize right off the hop that there is going to be discharge concerns, then we will need an order for physio, or physio will say you will have to consult OT because this guy is going to need equipment, that’s where all of this comes out and yeh, it gets passed back to the nurse on the floor who can pass it to the next nurse, so we have some continuity, and we want to start thinking about discharge when they are admitted: what are the barriers, the needs or is there none? (PI 1)

Hospitals rely on nurses for facilitating discharge yet, take for granted how nurses’ knowledge ensures patients will be quickly discharged.

Admission, discharge and transfer processes are a large part of nurses’ work, however, this work is largely organized by others. Monday to Friday, the multidisciplinary team consisting of the social worker, physiotherapist, utilization coordinator, dietician and nurses meet to discuss and facilitate discharge plans for patients. Even though all of these resources dedicated to efficient discharge processes are meeting during the week, the majority of discharges occur on Fridays. While nurses can expedite the discharge process, they state that they can only do so much in planning for discharge; ultimately, the physician will decide. Oddly, the majority of discharges occur on Fridays and before long weekends. “The use of beds is related much more to the way doctors determine who
enters than it is to the existence of the beds. Given that doctors determine who enters and leaves a hospital” (Armstrong & Armstrong, 1996, p. 76).

Usually Fridays are crazy...and that’s usually because doctors will have patients there all week and then...if they’re not going to be on call for the weekend then they discharge their patients on Friday...or they’ve been having tests all week and just...Friday is a magic day...and especially if it’s a long weekend ...they’re trying to...people want to go home by that time too...because it’s the weekend so they’re pushing for the doctor, I wanna go home...we’ve done all the tests...discharge ‘em home...like, I just worked last Friday and we had 10 discharges and admissions and that was because Craven...every department, like the people working above you, were pushing all the units and all the doctors, they need to clear beds out...because they were thinking that a lot of Craven people were coming into the ER and people maybe needing to be admitted so ...they cleared people out of our unit. (PI 10)

I don’t know why it is in hospitals but the discharges love to be Friday, they love to be Fridays, don’t they? So you have these ridiculous days on Friday and so you know, come, you know, come Thursday, Friday morning, all of sudden there is a, you’ve gotta get home care arranged, you gotta get this arranged so things can be very very busy, so why the push for Friday? I don’t know, it’s always been that way, always, always. (PI 3)

People that have been waiting for discharge...you know, the doctor will say...you know what...we’ll keep you over the weekend and if you are better by Monday, if your numbers are better...we’ll let you go Monday...so we get huge admission/discharge on Mondays and Fridays...Friday the doctors want to get rid of all of their patients so they don’t have to call, okay...so and so needs whatever, so huge amount of discharges on Fridays. (PI 7)

Friday...they put a pile of discharges on us...so that they can get them out and get those ones in so the doctors don’t have them for the weekend. (PI 9)

Fridays are usually bad because they’re trying to get people out of the hospital before the weekend umm...Mondays are usually bad, too, because they’re trying to get patients out after that. (PI 6)

Fridays are busy because it’s the start of the weekend and weekends are just wonderful because it’s slower. (PI 12)

Friday is crazy...weekend is quieter...other than that...that would be the biggest difference...Fridays are just really crazy...sometimes you could have a random Wednesday six discharges...not usually as much as a Friday. (PI 4)
Friday is the worst day to work...Saturday, Sunday is good...and Monday...it may not get bad until Wednesday...Friday is hell on wheels...lots of big surgeries...because you gotta get it done before the weekend and those are supposed to be emergency surgeries and these guys...they just get them in. You know this weekend that I just worked Dr. X was doing surgery all day and all night, we didn’t have beds...we had the hallways full. We have three admissions a night...you can go pretty hard...we have had runs of days where it’s ahh...the surgeries are only overnight...say breasts, whatever, we have done 15, 16 admissions because that’s how fast...and we do that more than you think...so that throws everyone into a loop...housekeeping is just frazzled out of their mind...they hate that floor for that reason...we’ve had three days like that and you’re discharging, too...and so you gotta do all of the teaching stuff...so it probably falls down a bit. (PI 11)

Shaped by the hospital agenda to expedite patients through the system, nurses participate in the discharge discourse without necessarily realizing that they are controlled by the ruling patriarchal practice of discharging on Fridays.

**Conclusion**

This chapter outlines the work processes, discourses and nurses’ descriptions of their experiences that became apparent in the observations and interviews. The analysis revealed the broader social organization which informs and controls nurses and their work in hospitals. Persisting ideologies continue to control nurses’ work however, their work also reflects the institutional discourses that are prevalent today. It is more and more obvious that nurses’ work has moved from patient care to hospital care. Nurses continue to work in a hierarchy of ruling relations. The deeply rooted patriarchy within hospitals organizes and shapes how nurses work. Patriarchal assumptions and nurses’ endless compromise and accommodation have resulted in the normalization of hospital problems as a routine part of nurses’ work. Nurses participate in ruling ideologies and discourses by absorbing system problems into their work. Central to the discourse of nurses’ work in
acute care are the influences of gender relations. The next chapter will go beyond acute care and move to the external influences that affect nurses and their work.
CHAPTER 5: EXTERNAL RELATIONS AND MOVING DISCOURSES

The Making of the Contemporary Nurse: Fatigued and Sick But Well Paid

The previous chapter identified the rulings that coordinate and shape nurses’ work within acute care as they were made known during my observations and interviews (DeVault & McCoy, 2002). Embedded in a patriarchal hospital hierarchy, nurses have unknowingly come to accept the conditions of hospitals as a normal part of their work. “Each day nurses juggle the orders of physicians, the needs of patients, the demands of families, the rules of the law, the bureaucracy of the hospital, and their own physical and emotional limits” (Chambliss, 1996, p. 93). Besides providing quality patient care, nurses are expected to work with the hospitals’ problems. Hospitals rely on nurses to absorb and manage problems of the hospital such as overcrowding, staff shortages and budget cuts to name a few. This assumption has brainwashed nurses into accepting the hospital’s problems as their work. Substantial evidence supports that this causes nurses’ fatigue, stress and sick time. “The stress, danger, exhaustion, and frustration that have become built into the normal daily routine of hospital nurses constitute the single biggest factor driving nurses out of the industry” (Lafer, 2005, p. 36). Nurses are constructed “across multiple conversations in different local settings and at different times” (Smith, 1999, p. 128). Sadly, nurses are organized as part of the problem.

Besides the historical, gender and patriarchal relations that influence nurses’ work, other social and political processes also rule and shape their work. Within the broader context, nurses’ work is influenced and organized by a number of external relations, most notably the Saskatchewan Union of Nurses (SUN) and the Saskatchewan Registered Nurses Association (SRNA), both of which are actively intertwined with the
work of government. This chapter; the second part of the analysis allows me to “identify specific sites, work processes, or discourses for further investigation” (Smith, 2006, p. 109). Several text-mediated discourses circulate in the public sphere and activate power relations which make “the work of the ruling/administrative apparatus...constructed as valuable and meaningful” (Luken & Vaughan, 2003, p. 125).

The nursing shortage, recruitment and retention, as well as overtime and fatigue are a “powerful part of the textually mediated discourses that shape the everyday activities of health care practitioners and their patients” (Rankin, 2001, p. 252). Particular ways of actualizing these discourses do not often represent the needs of nurses. Embedded within these discourses is an underlying message of blame. “Sick nurses are associated with decayed morale, poorer outcomes for patients and an economic burden for the health system and all Canadians” (Shamian & Villeneuve, 2000, p. 16). These discourses have evolved through the public sphere “under conditions of contemporary mass communication” (Smith, 1999, p. 173). This interpretation has resulted in the making of sick, fatigued and overpaid nurses. “The analysis illustrates how modern societies organize power by privileging some knowledge and marginalizing other knowledge” (Townsend, 1996, p. 188). Thus, this chapter reveals the public discourses and makes transparent how unions, governments, professional organizations and the media organize their actions to contribute to the discourse about nurses and their work in acute care. “Many institutional discourses...are moved into wider circulation through mass media and popularizing literatures” (McCoy, 2006, p. 118).
Beyond Acute Care:  
The Coordination and Organization of External Relations

Membership in the union and the professional association depends upon a nurse’s role. In order to practice in the province a nurse must be registered with the Saskatchewan Registered Nurses Association (SRNA), the professional regulatory organization. The SRNA sets the standards for nursing education and practice, which includes ensuring the professional conduct of nurses and their continuing competency in the province (SRNA, 2012). The focus of the professional organization is regulating the profession of nurses in the province and protecting the public. The SRNA works with government on any decisions that affect nurses. As well, all nurses working in acute-care hospitals (with the exception of nurse managers) must be members of the Saskatchewan Union of Nurses (SUN). The union’s primary responsibilities are bargaining contracts and representing its members in grievance or rights arbitration (SUN, 2012).

“Knowledge, judgement, and will are less and less properties of the individual subject and more and more of the objectified organization” (Smith, 1999b, p. 78).

The Power of a Shortage

For over 20 years, the nursing shortage has been a dominant discourse. “Discourses represent political interests and in consequence are constantly vying for status and power” (Weedon, 1997, p. 40). This discourse gained popularity and resulted in a “relatively common phenomenon” (Berliner & Ginzberg, 2002, p. 2742) related to years of warnings from the SRNA and SUN, government commissioned reports, extensive literature, and frequent media coverage. The nursing shortage has provided unseen power relations for unions, hospitals, professional organizations and the
government to position their agendas. The nursing shortage has been used in various ways: as a reason for bed closures; to threaten the public with increased wait lists; to threaten job action and negotiate for increased wages; to increase nursing education seats; to recruit internationally educated nurses; and, to create and implement new programming. “Textually-mediated discourses characteristic of everyday social relations in healthcare do not come about by happenstance, but they are to a certain degree controlled by others” (Winkelman & Halifax, 2007, p. 131). While there is no agreed upon definition of a nursing shortage “it is generally considered to be an imbalance between demand for employment and the available supply” (Oulten, 2006, p. 34S). Given this definition, one could easily qualify it as the hospitals’ shortage. This discourse has powerfully organized the work of SUN and the SRNA with government.

Since the advent of the nursing shortage in 1990, SUN, the SRNA and the government have discussed nurse vacancies with strategies focused largely on increasing the nursing labour in hospitals. “Nurses are entered into the debate as labor in the enterprise and subsumed within the goals and technological imperatives of medical corporations” (Diamond, 1984, p. 11). As a result, nurses have been conceptualized as a commodity driven by the needs of the hospital. “The Government of Saskatchewan understands how important health care is to the people of our province, and has committed to fill 600 nurse vacancies...during the first term of government” (Ross, 2009, p. 2). This discourse repeatedly constructs nurses as numbers and the reason for hospital problems. In 2009, the Regina Qu’Appelle Health Region reported in their annual report “two hundred and fifty SUN staff members were recruited in the calendar year 2008, and the number of bed days lost due to lack of staff has been falling” (RQHR, 2009, p. 29).
“The shortage, when seen as an isolated entity, assumes an ideological character that obscures the hospital as a protagonist in the crisis and implies that the shortage is one brought about by workers” (Diamond, 1984, p. 10). Essentially, it is implied that if there are enough women labourers, that they will do the work regardless of the conditions. The direct consequences of the nursing shortage have been situated within the hospital context and in most cases objectify nurses as the cause.

The nursing shortage led the way for the recruitment and retention discourse. The shortage “plays an active conceptual role in setting the terms in which organizational activities can be thought, discussed and evaluated” (McCoy, 1998, p. 396). Years of lobbying about the nursing shortage from SUN and the SRNA provided the incentive for the government to create “The Action Plan for Saskatchewan Health Care” in December 2001 (Government of Saskatchewan, n. d.). Key elements were aimed at developing strategies for the recruitment, retention and education of nurses. Since the vacancies in hospitals were not decreasing, the focus of recruitment and retention remained largely on recruiting nurses. One strategy included the construction of a website listing nursing jobs. Apparently, it was assumed that unemployed nurses spend their time on the Internet looking for jobs in Saskatchewan. The same government reported in 2007 that it “ensure that there is an adequate number of health providers to meet the needs of Saskatchewan residents” (Government of Saskatchewan, 2007). Apparently, if the right number of nurses are working, then things will be good for the residents of Saskatchewan.

The nursing shortage has provided leverage for SUN in negotiating contracts for its members with the government and for garnishing support from the public. Knowing that the media constructs strikes and unions in negative ways, SUN has recognized the
need for public support. “Strikes are unlikely, however, to succeed in making gains at the negotiating table without the support of the public and the media” (Chadwick & Thompson, 2000, p. 495). In 1999, with the threat of strike looming in the province, SUN placed billboards up across the province saying “overworked + underpaid = nursing shortage” (SUN, 1999, p. 1). SUN cleverly used the number of vacancies as a key bargaining opportunity prior to the election in 2007. Prior to that election, SUN reported to the media on the findings of their annual audit regarding vacancies and bed closures. At the same time, SUN met with the then opposition Saskatchewan Party health critic, Don McMorris, who later went on to become the Saskatchewan Party’s Minister of Health, about the nursing shortage. Because of gender and a lack of power in the political economy of health care, nurses have used strikes for monetary increases (Chadwick & Thompson, 2000). Strategically, the number of vacancies was SUN’s power in negotiating a lucrative contract and averting a strike in 2008.

The nursing shortage was also the force behind SUN establishing a partnership with the newly elected Saskatchewan Party government. The partnership agreement is described as meeting the “urgent need to stabilize and rebuild the Registered Nurse and Registered Psychiatric Nurse workforce in Saskatchewan to ensure the health care system can deliver high quality, timely and accessible health services” (SUN, 2008). Essentially, the partnership is a committee of government, SUN and health region representatives who strategize on how to spend the allocated monies. This partnership resulted in creating the “Joint Health Region/Sun Retention and Recruitment Fund”, a 60 million dollar fund that is managed by the agreement, which allows SUN members and the Ministry of Health to work with health regions on the funding to hire 800 registered
nurses as well as funding for retention initiatives (SUN, 2009). In October, 2010, SUN and Government of Saskatchewan issued media releases about the hiring of over 800 registered nurses and registered psychiatric nurses “fulfilling the provincial government’s election commitment” (Government of Saskatchewan, 2010b). Obtaining the right number of nurses overshadows the underlying issues and gives little attention to the retention of nurses already working.

The nursing shortage has been used by the SRNA to question the quality of care provided by nurses. At the SRNA annual meeting in 2006, the then executive director, Donna Brunskill, reported that the public has confidence in nurses but because of the nursing shortage, believes that the quality of care has decreased in the past five years (Smith Brazil, 2006). In 2007, the Saskatoon Star Phoenix reported from the SRNA viewpoint on the nursing shortage saying “It means needless pain and suffering for patients, as well as more needless government spending in the long run due to inadequate care” (RN shortage, 2007). With an inadequate number of nurses to provide the care, the ones who are working are considered to provide suboptimal patient care and contribute to increasing mortality rates and length of stays (Kurtzman, 2010). “The system is one that undermines the confidence of the nurse, restricts the contribution that she can make, and sets up a constant questioning about the quality of care that is being delivered” (Davies, 1995, p. 95). Ironically, when there are enough nurses to do the work, “substantial evidence” shows that nurses improve patient outcomes (CNA, 2004). Recently, this research has been questioned too, as Kurtzman (2010) states that even in “a stream of studies over the last decade linking nurse staffing variables to patient outcomes, the nurse-value case has not been fully made” (p. 53). Essentially, nurses cannot be
Monetary incentives for the recruitment and retention of nurses have become common approaches to addressing the shortage of nurses in hospitals. “Heavily constructed and maintained through texts and documents, discourse transports ideology from individuals to governing bodies, to practices within bureaucratic administration, to extended social relations” (Wright & Rocco, 2007, p. 643). Since 2000, governments have given millions of dollars in bursaries to retain nurses in the province (Government of Saskatchewan, 2000; Ross, 2009). In December, 2008, the newly elected government reported on its website that “Saskatchewan is turning the corner on nursing vacancies” and “that the province has 50 fewer full-time equivalent (FTE) vacancies than last year” (Government of Saskatchewan, 2008). Several paragraphs discuss the monies that target the nursing shortage. While money may entice nurses to stay in the province, this continues to absolve the hospital of any responsibility in addressing the deeper reasons for the nursing shortage. By providing incentives, the government is seen as actively filling nurse vacancies. Incentives skilfully feed into the perception that the government is active in addressing the nursing shortage. The public believes that there will be enough nurses to keep them safe and to care for them while in the hospital. The professional association believes that there will be enough nurses to provide safe and quality care to the people of Saskatchewan. The union endorses the government in keeping their campaign promise to address nurse vacancies. Thus, “the shortage begins in the vested interests of hospitals and ends with solutions that reinforce these interests” (Diamond, 1984, p. 11).
Hospitals are also using monetary incentives to recruit and retain nurses to work in acute care. In September 2007, the RQHR started the employee referral program which pays $1000.00 to new employees who are hired and passes the probation period while the referring employee receives another $500 (RQHR, 2008). Rewards become a clever way of luring other nurses to work within the endemic problems. Hospitals focus on their labour needs but not the needs of the labourers. Filling vacancies takes the responsibility off the hospital except to pay the nurse finder. “Market solutions...may help moderate the problem in the short term, but will not resolve the fundamental imbalances that plague nursing” (Berliner & Ginzberg, 2002, p. 2744). Governments and hospitals make decisions based on ideologies of the scarcity of human resources and ignore the context within which nurses work. “All of this suggests the bureaucracy of the acute health care world is ignoring to its peril the strengths of its most peerless asset, as is demonstrated by the exodus of nurses from the system”(Summer & Townsend-Rocchiccioli, 2003, p. 171).

Adding nursing education seats to increase the supply of nurses is also a common strategy in remedying nursing shortages. Over the past two decades, governments have responded to SUN and the SRNA’s lobbying on the nursing shortage by increasing nursing education seats in the province. “Unless nursing training capacity expands substantially, the projected nurse shortage will occur” (Seago, 2006, p. 96). Since 1996, seats have steadily increased from 180 seats to the current 690. For the first time in Saskatchewan history, both the University of Regina and the University of Saskatchewan will offer nursing education programs in the province beginning in the fall of 2011. This, too, was in keeping with the Saskatchewan Party’s 2007 election promise to increase nursing seats in the province. Solutions are repeatedly aimed at increasing the supply of
nurses while ignoring the hospital environment. “As long as the conditions on the job are not improved, expanding nursing schools amounts to little more than a bait-and-switch strategy, hoping that student nurses will not discover the downside of their profession until it is too late” (Lafer, 2005, p. 33).

It is assumed that nursing graduates will fill the vacancies and then work happily ever after in their lifelong nursing career. “Without the promise of improved working conditions, it appears that a sizable percentage of young nurses will leave the nursing profession” (Lavoie-Tremblay, O’Brien-Pallas, Gélinas, Desforges, & Marchionni, 2008, p. 731). Not surprisingly, once nurses start their jobs in acute care, they go through what Boychuk Duchscher (2009) calls “transition shock” experienced from working in “an oppressive hierarchy amongst the nursing staff, and passive–aggressive styles of communication between nurses and physicians” (p. 1108). Besides transition shock, research shows new nurses are leaving the profession within 5 years or fewer after beginning their jobs (Goodin, 2003; Hodges et al., 2008; Hodges & Keeley, 2005). Ross (2009) concurs in her report to the Minster of Health in Saskatchewan stating “New nurses coming into the workforce are more likely to leave the nursing profession entirely after only a few years of practice” (p. 38).

The nursing shortage has also provided the impetus for the Saskatchewan Licensed Practical Nurses Association (SALPN) to strategically advance their scope of practice and increase the number of Licensed Practical Nurses (LPNs) working in acute care. As the nursing shortage became more apparent, practical nursing schools began teaching skills that had previously been performed only by RNs. The Canadian Union of Public Employees (CUPE), the largest union in Saskatchewan, which represents LPNs in
acute care, released a brief in 1999 regarding the underutilization of LPNs in the province. Medication administration, intramuscular injections, intravenous therapy and blood transfusion became part of practical nursing curricula. Most hospitals were reluctant to reassign new skills to LPNs (CUPE, 1999). Because of the additional skills and knowledge, in April 2008, the practical nursing program was expanded to 65 weeks with students receiving a diploma instead of a certificate.

I recall teaching in both the practical nursing program and in the clinical area during the time when LPNs started giving medications in acute care. Several LPNs confided that they believed that the RNs didn’t trust or value them while RNs asked about their education. Sadly, no one took the time to facilitate a process for working together; for the most part, they had to figure it out for themselves. (FN 7)

The reorganization of the work in acute care resulted in turf protection conflicts as RNs and LPNs struggled to reorganize their work. “In recent years a highly publicized RN shortage has led hospitals to retain rather than displace LPNs and aides” (Brannon, 1994, p. 159). Many diploma-educated nurses believed that the expanded practical nursing program replaced the previous two-year nursing diploma and was designed to move RNs out of acute care. “While there are overlapping scopes of practice, in some cases RNs are better positioned to work in intensive care, emergency wards, health management and administration, education and research” (CUPE, 2008, p. 8). CUPE reported that “Saskatchewan is more reliant on RNs than most other provinces” (CUPE, 2008, p. 4) and suggested filling RN vacancies permanently with LPNs as a means of cutting costs in hospitals. “Approximately 145 vacancies are being temporarily filled by LPNs due to the inability to recruit RNs to these positions” (CUPE, 2008, p. 7). Available in greater supply and with cheaper labour costs, LPNs are seen as a way to fill vacancies and save money in hospitals. “Cost, not quality of patient care, is typically the driving
priority behind many healthcare decisions” (Mitchell, 2003, p. 220). Yet, researchers claim RNs improve patient outcomes and construct nurses as a sound investment for hospitals (Dall, Chen, Seifert, Maddox, & Hogan, 2009). If cost containment and filling vacancies are the driving forces of hospitals, then SUN, the SRNA, the government and researchers have all contributed to maintaining the shortage of nurses and escalating costs in hospitals.

For over 20 years, SUN, the SRNA, and governments have used the nursing shortage to organize their positions. Nurses are unmistakeably a strategic commodity in the midst of the hospital’s power. This has undeniably provided the force for increasing nurses’ wages, profiling the profession, and exposing working conditions to government and the public. Yet, the hospital’s power leaves nurses and their work situated squarely within prevalent system problems. As Lafer (2005) suggests “there is no shortage of qualified personnel—there is simply a shortage of nurses willing to work under the current conditions” (p. 27). The recruitment of nurses has been the main focus of governments, SUN and the SRNA while retention is given little attention. The message is clear: labourers are the priority for hospitals. “Why hasn't the hiring of 600 additional nurses in recent years eased staffing shortages, as the Saskatchewan Party government said it would?” (Situation Critical, 2010). Evidently, the number of nurses is more important than their actual work; the ones who are most productive keep the hospital running.

“Retention strategies and supportive human resource management practices are required to sustain the existing number of practicing nurses, to maximize their productivity and to reduce the outflow of those leaving the profession” (Griffin et al., 2009, paragraph 3).
The shortage has been a powerful motivating force; nevertheless, focusing on the number of nurses neglects the real issues in hospitals.

**The Elephant in the Room**

In 2007 Torgerson reported in a paper prepared for the Office of Nursing Policy, Health Canada:

According to Canadian nurses, they are still exposed to unsafe working conditions, they face unrealistic expectations for working overtime, they are understaffed and feel unsupported and disrespected. They continue to have high rates of depression and physical pain. They also feel that the quality of patient care has deteriorated or stayed the same, and that patients are being exposed to adverse events (p. 21).

Hospital conditions are evidently not secret; yet, they are accepted as just part of nurses’ work in hospitals. Nurses are known to work in adverse conditions and hospitals have come to rely on nurses to manage their problems. Another poorly kept secret is how the conditions of hospitals affect nurses. Every shift, nurses work within an ideologically embedded patriarchal hospital hierarchy that creates adverse working conditions. It is taken-for-granted that nurses will work within the stressful and challenging conditions of hospitals. Because of these conditions nurses are labelled as stressed, fatigued and high users of sick time; or simply stated a problem for hospitals. “Just as the skills are all too frequently rendered invisible by gender, so too are many of the hazards women frequently face in the relations and conditions of this work” (Armstrong et al., 2008, p. 9). Years of research provide ample evidence that most nurses’ health will be somehow affected by the conditions of their work. “Seven in 10 Saskatchewan nurses (71%) had taken time off work because of a health problem in the last 12 months – the highest rate in Canada” (Kellen, 2007, p. 8). Based on the evidence, one could assume that hospitals
knowingly put nurses in conditions that will result in stress, fatigue, burnout, and mental and physical injury. Thus, given the known conditions, nurses are shaped to become injured, burned out, stressed and fatigued by their work in acute care.

With research demonstrating how the restructuring of the 90s changed working conditions for nurses in hospitals (Health Canada, 2002; Rankin & Campbell, 2006), the nursing shortage discourse gave rise to the discourse on working conditions. “Nurses appear to be shouldering in even more Herculean ways the complexity of patient care, short staff, long hours, and an environment perceived to be hostile to their own needs” (Summer & Townsend-Rocchiccioli, 2003, p. 170). Construed as creating an unhealthy workplace, the working conditions are discussed as contribut ing to the nursing shortage. Yet, within the working conditions discourse, the focus remains on nursing labour. “The episodic shortages of nurses that have plagued health care systems throughout the world since at least World War II have characteristically led the nursing leadership to devise and revise strategies to improve the image of nursing, deal with negative stereotypes, and to attract a “new breed” of recruits to the profession” (Nelson & Gordon, 2006, p. 255).

The working conditions discourse has opened the door for government, unions, professional associations and hospitals to actively engage people and organize their actions. This textual representation is important in understanding how the government, SUN and the SRNA activate the power of hospital working conditions discourse to appropriate their vested interests. Each has its own imperative and is organized to represent working conditions based on its specific interests. In the space of a decade workplace initiatives, government union partnerships, and lean strategies have been framed to address working conditions in acute care. Not surprisingly, much of the focus
is placed on the needs of hospitals while overlooking the needs of nurses. More surprising is the fact that such initiatives rarely extend past the pilot sites and are never sustained for more than the term of the government in power. “The textual discourse reveals the importance of work activities of researchers, politicians...and other professionals in clarifying and resolving” (Luken & Vaughan, 2003, p. 125).

In the much publicized report, *Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses* (Health Canada, 2002), 51 recommendations support the improvement of working conditions. These recommendations are discussed in the three broad categories: “resolve operational workforce management issues and maximize the use of available resources; create professional practice environments that will attract and retain a healthy, committed workforce” and finally, “monitor activities and generate and disseminate information to support a responsive, educated and committed nursing workforce” (Health Canada, 2002, p. 2). In an attempt to improve working conditions, work life quality and healthy workplaces have been construed by governments, unions and the professional association as solutions. Oddly, many of these initiatives are rooted in meeting the labour needs of hospitals. Organizational priorities take precedence over the needs of the nurses. However, workplace initiatives are creatively packaged as solutions to recruitment and retention. “Healthy work environments (HWEs) are essential for the retention and recruitment of nurses and for health system sustainability” (Griffin et al., 2009, paragraph 1). Regardless of the conditions and their effects on nurses, the first priority is meeting hospitals’ labour needs.

Since the release of the report in 2002, a scant number of initiatives have been implemented in the province. The first such program designed at addressing working
conditions, *Improving Nurses Workplace for Health*, was introduced by the SRNA in 2001 (Smith Brazil, 2003). This program engaged nurses in addressing concerns and taking action in their workplace. Part of the program included a two-day alternate dispute resolution workshop that “combined lectures, discussions, and group exercises to improve group members’ problem-solving, conflict resolution, communication, and leadership skills (*Improving Nurses Workplace for Health*, 2003, p. 2). It is assumed that if everyone can get along the workplace will be a quality place to work.

Situated within the nursing shortage, SUN too, initiated two applied research projects to improve working conditions. The first, in 2007, the 80/20 project, co-sponsored by RQHR and SUN, was implemented on one unit within the RQHR. It was proposed that nurses would spend 80% of their time providing direct patient care and 20% on professional development (LeMoal, n.d.). The mentoring program, an initiative implemented in 2008, was described as a solution for new nurses to be supported during their transition into their role (*Government of Saskatchewan*, 2010a). Because of the inherent power of hospitals, the programs are framed within the context of addressing the nursing shortage and/or decreasing hospitals’ labour costs. “Low sick time, decreased overtime and turnover costs and lack of agency use all contribute to keeping the variable direct labour cost from increasing at a significantly higher rate than on the comparator units” (LeMoal, n.d., p. 5). These programs are built around addressing working conditions; yet, nurses are positioned as the ones who need to take responsibility in fixing the hospitals’ problems. This assumes that nurses are the ones who need to change rather than the system.
Nurses are led to believe that their contributions will improve working conditions. “Even where quality workplace initiatives have been introduced, there are few evaluations done which assess their impact on nursing and patient outcomes” (Torgerson, 2007, p. 3). Funding for such initiatives was provided by government and not hospitals; however, because of the costs, funding was ceased resulting in the discontinuation of the programs. Still, the real meaning persists: nurses are not worth the long-term investment. Hospitals have the money when it serves their needs. The problem is not a shortage of funds but a misunderstanding of the realities of hospitals’ real priorities. Approaches to addressing working conditions are infrequent and never sustained. Most the government, professional association and union’s so called nurse initiatives are organized to improve the hospital’s structure and not the work of nurses.

**The Making of a Lean Hospital Machine**

The efficiency discourse in health care has been evident since “the health reforms of the early 1990s” which “were driven by the need for greater efficiency” (Marchildon & O’Fee, 2007, p. 64). More recently, lean discourse has been making its way into health care. “The introduction of new public management ideology has resulted in an increasing emphasis on managerialism and market-oriented mechanisms for care delivery” (Hentinnen, LaPointe, Pesonen, & Vanhala, 2011, p. 4). In 2007, the provincial government provided the Health Quality Council (HQC) with five million dollars of special funding to launch “Accelerating Excellence, a multi-level program to rethink, redesign and renew healthcare” (Coutts, 2010, p. 21). HQC is an organization “with a mandate to not only measure and report on healthcare but also to work with a range of partners to improve the province’s health system.” (Coutts, 2011, p. 26). The
Accelerating Excellence program resulted in “a group of HQC staff, leaders from the nursing unions and regulatory bodies, health region staff, and the deputy minister and minister of health” traveling to England to explore their recently launched lean healthcare initiative, Releasing Time to Care: The Productive Ward™ (RTC™) (Coutts, 2010, p. 21).

Based on lean methodology, RTC™ evolved from Toyota Production Systems, a program designed to increase operational efficiency and improve productivity (Waring & Bishop, 2010). The program is touted as improving the work environment by reducing waste and increasing efficiency which allows “more time at the bedside for hands-on care” (Dagnone, 2009, p. 35). RTC™ “is teamwork: front-line workers gathering and analyzing evidence and working together to improve their environment and their activities” (Coutts, 2010, p. 21). Following successful pilot projects in Moose Jaw and Regina, the program was endorsed by the Ministry of Health, SUN and the SRNA and implemented in all nursing units across the province in 2010. On May 11, 2009, the then SRNA executive director, Donna Brunskill, gave accolades to the provincial government for committing to the implementation of RTC™ by saying it was moving in the right direction in addressing the projected RN shortage of 60,000 by 2022 (SRNA, 2009). SUN showcased the RTC™ initiatives over six pages in the October 2010 issue of SUNspots, a newsletter for its members (SUN, 2010). Nurses undoubtedly agree that they would like to spend more time with their patients. Time is conceptualized as the nurses’ problem while the RTC™ program is really aimed at improving nurses’ productivity. As well, RTC™ addresses the public’s concerns about “the need for more time for direct interaction” as reported in the highly publicized Patient First Review in 2009. The
program is strategically marketed as a way of providing more time for nurses to be with their patients; this garners approval from the public, hospitals, the union, and the professional association. With nurses more productive so that they are able to spend more time with their patients, the attention shifts away from working conditions. While “the terminology may sound attractive” and outwardly appear like hospitals are patient-focused, unknowingly “it is based on an engineering model of the body and is primarily aimed at reducing costs and controlling workers rather than improving care” (Armstrong & Armstrong, 1996, p. 134). In the process of observing, I note in my field notes how the RTC™ program has organized the unit.

Anything that can be moved is outlined on the floor with coloured tape. Nurses work with the life and death of patients yet they need a simple coloured piece of tape to remind them to return something where they found it. Added to the chaos of sounds, people are numerous signs on the walls to serve as reminders for nurses to remember to do something related to their work. For example, remember to enter changes to the SCM system three times a day (adding to the nurses work and facilitating the work of other departments). As you walk onto the unit, the Releasing Time to Care bulletin board provides information about the program and what is occurring on the unit. One sign reads: “2190 minutes = 53 minutes to complete morning care on their 10 patients (daily assignment) = was reduced to 15 steps per patient. Reducing the walking time to 3 minutes per 10 patients. In a year, a remarkable reduction of 21.6 km or 280 hours of walking.”

Since when is nurses’ work measure by the number of steps she takes in day? How does this accommodate for hallway patients? for listening? for comforting? for knowledge? for bariatric patients? pressure to discharge? How does nurses’ work become measured by the number of steps she takes? A nurse notices me reading the information and states “At least we know why we are exhausted when we got home...really though...I’m still always exhausted...but at least it helped to clean things up around here.”

During morning report, the manager explains that government officials and media representatives will be coming by the unit to promote the RTC™ program. Later that morning, as nurses are scurrying around, the entourage enters the unit and interviews the manager in the hallway. (FN8)

Throughout the program, work processes are evaluated and redesigned to create an efficient work environment. Nurses integrate their efficiency-orientated work in the
“taken-for-granted accomplishments of quality improvement in hospital care” (Rankin & Campbell, 2006, p. 153). Armstrong and Armstrong (1996) discuss that there is little evidence that suggests “techniques designed to increase the production of goods such as cars and services...will prove effective in the health care sector” (p. 112). Similar to that of factory workers, nurses’ work is equated to how quickly and efficiently they can get their work done. “Denied more say in how the work is organized, they are instead encouraged to adapt to the new environment” (White, 1993, p. 104). Several nurses commented that the unit was more organized, however, this did nothing to offset the work of increasingly acute patients, overcapacity patients and the push to discharge. This is what prevents nurses from spending time with their patients. “Overwhelming evidence proves that nurses’ workloads have intensified” (Cooke, 2006, p. 231).

Improving processes has done little to offset nurses’ real work. As one nurse commented, “It necessarily hasn’t worked that it’s more [time], but things [supplies] are better all together.” While these strategies are promoted as supporting nurses, in actuality they support the hospital and government public relations. “Managers and bureaucrats use the tools of re-aggregating work, rationalization of activities and staffing levels, re-organization and re-structuring of organization and awards as ways of controlling the productive process” (Kermode, 1994, p. 112). Lean strategies benefit the hospital however problems of overcrowding and increasing acuity remain. RTC™ is constructed as giving nurses more time with patients yet, this section reveals how the underlying efficiency ideology organizes nurses to actually be more productive in their work.
An Easy Target: Nurses Overpaid, Sick, and Fatigued

This section will elaborate on how the media’s power relations adds to discourse in constructing nurses as overpaid, sick and fatigued. “Unions representing registered nurses have enjoyed some recent success in demanding better wages and conditions as well as a strategy to address future demands as a result of perceived shortages” (Armstrong et al., 2008, p. 114). In 2008, the recruitment and retention discourse provided SUN with the power to negotiate a 35% wage increase and other monetary benefits in the nurses’ contract settlement.

On Sunday after six days at the bargaining table, SAHO tabled what it is classifying as a historic document that is responsive to the Saskatchewan Union of Nurses (SUN) demands for wage parity and language to address critical retention and recruitment issues. (Saskatchewan nurses get 35% offer, 2008)

Increased wages are heralded as a remedy to the nursing shortage. However, Censullo (2008) states “To date, no increase in the nursing supply has materialized in response to the increase in wages” (p. E12). Increased wages were also suggested as a way to improve nurses’ morale. “When it comes to workplace morale, attracting workers to the profession and even keeping salaries reasonable could work - if the nurses' 35-per-cent catch-up settlement in 2008 is any indication” (Mandryk, 2011). While monetary gains have been made for nurses, embedded gender and power relations remain primary to discursively blaming nurses for hospitals’ financial problems.

*The Saskatoon Star Phoenix* reported,

If they strike this year, though, you have to wonder how many people are going to cheer on a group that turns up its collective nose at $86,000 a year. This is a pay level that the average worker in Saskatchewan can only dream of. (Honk if you think, 2008).
The average worker is also not a female who works in an institution open 24 hours seven days a week. When nurses are situated within the context of labour costs, they become an easy target. Because the majority of nurses are women, monetary gains easily shadow the working conditions that they must endure. “There is little evidence that front-line nurses are experiencing an improved working life” (Priest, 2006, p. 4). The wage increase has done little to change working conditions in acute care except to portray nurses as overpaid and cast blame on them for hospitals’ escalating labour costs.

This discourse shifts the focus to nurses’ wages related to overtime costs. “SUN members received a 35-percent pay hike two years ago in a contract that guarantees double pay for overtime” (Cowan, 2010). Because of their salaries, nurses are portrayed as overpaid and the source of the health region’s financial problems. For example, the Leader-Post reported on nurses’ overtime on August 12, 2010, stating that Health Minister Don McMorris “sent signals to the health regions ...to look at efficiencies and a lot of them cited premium-time pay”. In the same article Ken Rasmussen was quoted as saying “I think almost everybody recognizes the settlement to the nurses was a bit off the radar, a bit excessive and apparently it hasn’t solved the problems” (Cowan, 2010). Rasmussen’s simplistic thinking cannot imagine that workers deserve a fair exchange for their labour, even if they are women.

Presumably, nurses do not need to be paid similarly to other professionals; after all, is it not something that women do naturally. Gender is textually mediated by what the public thinks that nurses should earn. Later that year, the Regina Leader-Post reported that the top five RNs “earned between $180, 530 and 243, 540 and the health region said overtime was the biggest factor in its $6-million deficit” (Health Regions, 2010). More
recently, the front page of the *Regina Leader-Post* featured the salaries of the region’s top five wage earners because of working overtime (Cowan, 2011). On August 4, 2011, the *Saskatoon Star Phoenix* front page headline stated “Overtime reduced, nurses cash in” (Scissons, 2011). This repeating discourse objectifies nurses as overpaid and therefore responsible for hospitals’ financial problems. “The abstractions by which individuals are controlled are relations of exchange between people mediated by money and commodities” (Smith, 1999, p. 77).

Nurses are portrayed as making excessive wages because of the overtime they work for the hospitals’ needs. “It is not difficult to create a scenario in which this recent crisis centers on hospitals, with nurses ending up as scapegoats in a situation over which they have little control” (Diamond, 1984, p. 10). In actual fact, this really means nurses are being paid too much for their work. In October, 2007, the *Saskatoon Star Phoenix* reported about the opening of three critical care beds in the Saskatoon Health Region (SHR) which resulted in nurses’ overtime. “22 critical-care beds typically operate in the region, it has expanded the number to 25 by paying nurses overtime” (Critical care shortage, 2007). Ironically, it is acceptable to make nurses work overtime if it keeps beds open; however, if it costs the hospital money then nurses become the brunt of problem. For years, hospitals have used overtime to manage their labour needs. However, since the latest contract settlement to which hospitals agreed, nurses are discursively situated as costing hospitals too much. This discourse diverts attention away from working conditions to the cost of nurses’ salaries. Hospitals can conveniently rationalize their deficits to the government and the public by blaming nurses.
Another discourse that circulates among governments, hospitals and the media infers that overtime costs and deficits are related to nurses’ sick time. “Enhancing nurses’ salaries has done nothing to change the work environment and sick time seems to be the only way that nurses can manage” (Waterworth, 2003, p. 46). Nurses abide by the Code of Ethics that requires them to be aware of their “necessary physical, mental or emotional capacity to practice safely and competently” (CNA, Code of Ethics, 2008). Given their working conditions, it is no wonder that nursing is labelled as the sickest profession. Yet, hospitals blame nurses for using their sick time as a means of taking time off from work. Last year, after recently announcing a seven million dollar deficit, the SHR reported to CBC news that sick time was higher following a concert or sporting event. “According to the region, registered nurses call in sick more than anyone else…the health region says it has to trim sick time or cut jobs” (Absenteeism coincides with concerts, says health region, 2010). One week later, the Chief Executive Officer of the SHR, Maura Davies, was quoted as saying “Staff view sick time as a benefit they are entitled to use” (Lemstra, 2010). The same article discusses that “entitlement and earned…are words used to explain sick time and that managers should not sign agreements with such words” (Lemstra, 2010). These objectifications are designed to create stories that blame nurses and obscure the real reasons for using sick time.

Torgerson (2007) reported that nurses are “still expected to work both paid and unpaid overtime, are under intense time pressures, and are exposed to physical assault and injury. They continue to have high rates of injury and absenteeism due to health-related problems, and have high rates of depression.” (p. 3). Nurses’ health is not significant in keeping the labour cost of nurses in check. Because of nurses’ increasing
sick time, health regions have taken measures to monitor their sick time. “The region is concerned about the impact of excessive overtime ...and now has a software package that tracks employees’ hours and sick-time utilization.” (Overtime costs, 2011). Interestingly, Lemstra (2010) reports that Saskatchewan nurses actually use less sick time than others; 102 hours versus the national average of 116 hours. He goes on to say “It seems unfair to overload front-line care providers with work and then suggest they are abusing sick time” (Lemstra, 2010). Perhaps nurses have finally learned to use their sick time based on their needs and not those of the hospital. “Women’s activities are often obscured or distorted by the forms of thought and speech available, especially in public discourse” (DeVault, 1991, p. 227). The conditions under which nurses’ work are frequently discussed in the public sphere.

Regardless of a nurse’s health, or how the conditions affect her health, she needs to do her work in acute care. Oddly, hospitals notice nurses when they are not there or when they cost too much. Further to this discourse, my interviews and observations reveal how nurses’ work contributes to the making of a sick and fatigued nurse. These accounts make known how nurses’ actual work affects their health. Because of this nurses’ physical and physiological health are shaped by the conditions of their work. “It is clear that waged work cannot be separated from the rest of women’s lives” (Doyal, 1995, p. 174).

Three is pretty tiring...two is good but the third night you’re still pretty tired...being on your feet all those hours for that long. (PI 5)

Sometimes we don’t have time to care, besides feeding, they poop and pee...all have needs and you have to remember to do this, do that...easy to forget ...last night I didn’t take my break because I knew I would never get out of here. (PI 12)
I think I’m still a little soft-hearted still and I don’t deal with a lot of things the way that they should be dealt with. I went home bawling three nights in a row over the weekend because I was stressed all the time. I think that it’s about being young. I’m faced with my own mortality and I get stressed and upset about it even though I know it’s for the best sometimes. (PI 3)

Sometimes you listen to report and think...I should have called in sick...or is this worth it? (PI 10)

It’s only nine a.m. ...what next? (PI 6)

I live for my breaks... you are always in a rush...so it’s nice to have a couple minutes to sit down. (PI 8)

You are on adrenaline after your shift, always thinking about your patients ...did you make a med error, what did I forget...did I tell the next shift...it takes sometimes days to come down. (PI 5)

Sometimes I drive home thinking what did I do wrong today? (PI 3)

It is hard when a patient dies...knowing all the things to do. If you haven’t been through it much and you’re trying to comfort them...you don’t want to say the wrong thing and you don’t want to not say anything. (PI 10)

When you have situations like that...umm...you finish your day...like on some sort of adrenaline mode or that you’ve got stuff you gotta get done...and it’s the end of the day when you’re walking out that door. It’s when that stuff hits you. (PI 5)

You take it home with you and you’re exhausted trying to deal with all the days. (PI 11)

I’m so glad I’m working this weekend, my boyfriend is out of town. I just come home from work and sit ...because when you come home sometimes your spouses don’t realize all the dynamics that you’ve dealt with and still like going a hundred miles a minute and umm...you just need time to process that all...because you can’t do it at work. (PI 12)

By day three I’m so over stimulated and some of my friends that work Monday to Friday don’t understand when I don’t want to go out after my shift...sometimes it’s even hard to talk to my husband and kids...I just need down time ...where no one talks to me...not even the TV. (PI 2)
I used to hide in the garage if I had a bad day because I knew that I wasn’t going to be good with my kids...sometimes you are just empty. (PI 6)

You still gotta try to do everything...if you weren’t short that day because you can’t walk away giving. (PI 5)

Overtime discourse is also associated with the discourse on nurse fatigue. The SRNA discussion paper, *Hours of work, Fatigue and Patient Safety*, begins with “In today’s work environments, RNs are frequently faced with increased requests and requirements to work extra shifts and overtime” (SRNA, n.d.). The paper links research on patient safety and nurse fatigue. Researchers agree that working overtime contributes to fatigue (Braithwaite, 2008; Ruggiero & Pezzino, 2006). Caught between a rock and hard place, nurses are expected to work overtime within abysmal working conditions and are then called fatigued. Nurses have long been working in conditions that are known to cause fatigue. The fatigue discourse began to circulate when researchers found connections to patients. “The shortage has produced a revolving cycle leading to overburdened nurses who are fatigued and more prone to committing medical errors, which is further complicated by increased patient morbidity and mortality” (Caron, 2004, p. 7).

Undoubtedly, given the scope of nurses’ work, fatigue could have the potential to affect patient care. In August, 2010, the *Regina Leader-Post* reported that the Health Minister, Don McMorris, “isn’t aware of any incidents where patients were at risk because staff worked extended hours” (Cowan, 2010). Nurses have learned the importance of safety in their working environments. Throughout their shift, nurses constantly check on their work and the work of others to ensure patient safety. Linking patients’ safety to nurses’ fatigue not only brings attention to patient care, but also shifts
the focus to nurses’ practice. Since nurses are with patients around the clock and are closest to the patients, who better to look to than nurses as the cause? “By locating blame with individuals rather than structures, these discourses legitimate the hierarchies of access to resources that produce inequities” (DeVault, 1991, p. 230).

Because of nurses’ overtime, nurse fatigue has surfaced in the news, the professional association and the union. The Regina Leader-Post reported that “The Ministry of Health, the Saskatchewan Registered Nurses Association, and the health regions are monitoring the situation” of nurses’ overtime and patient safety (Cowan, 2010). While much of the focus remains on patients, Caron (2004) suggests that “fatigue could potentially affect the physical well being of nurses” (Caron, 2004, p. 4). Nurses’ well-being becomes important if they cannot work or if it affects patient care. Solutions such as creating full-time jobs and limiting the number of shifts that nurses work are suggested to aid nurse fatigue. “Guaranteeing available full-time positions for graduates will ensure they'll stay in the province rather than leave for greener pastures. It will reduce the demands on our fatigued RNs who have been working overtime continually” (RN shortage, 2007). Because of the increasing news; the SRNA sent an e-mail to all of its members “reminding” them about how excessive overtime can lead to fatigue, making medication errors, and even the possibility of verbal and physical abuse from clients (Mandryk, 2010). Shortly, following the SRNA released a discussion paper which suggests limiting “shifts to 12.5 hours and 48 hours a week” (SRNA, n.d.).

Hiring more nurses and suggesting nurses limit the number of their working hours shifts the focus off the hospitals’ conditions. The priority of hospitals is meting labour requirements, not the number of hours nurses work. Hospitals rely on nurses to work
overtime and then assume that they will not become fatigued. It is the hospital organization that causes nurse fatigue; yet the context is rarely given any merit. Shifting the blame to nurses minimizes the hospitals’ problems. The labour discourse connects with the discourse on overtime which flows into the fatigue discourse; these all serve to shape how nurses are constructed by external relations. This discursive process “through which certain activities are selected and named” indicates that nurse fatigue is “intended to identify particular problems and particular solutions” (Walker, 1990, p. 65). Structured within the labour needs of the hospital, nurses’ fatigue is considered their problem.

**Conclusion**

This section reveals how nurses are organized by the discourses that circulate within the external relations of unions, government and the professional association. These discourses “are discursively shaped and connected with one another” (Mykhalovskiy, 2001, p. 273) and add to situating nurses with hospitals’ problems. While the nursing shortage and how recruitment and retention intersect have merged with the meta-discourses of overtime, working conditions and fatigue, they are still an inherent part of the social discourse that blames nurses. These coordinating discourses are crafted as supporting nurses; however, more often than not, they feed into the hospitals’ needs.

As a system of control, the ruling relations have been particularly effective in ensuring that, in the main, whatever knowledge is produced is not oriented to the needs and interests of the mass of people, but to the needs and interests of ruling systems. (Smith, 1999, p. 16)

The purpose of this section is not to blame but to expose and create an awareness of how external relations influence and shape nurses and their work in acute care. External relations carry “back into the actual setting, reorganizing and influencing the
activities of people and creating new problems to be mediated and negotiated” (Rankin, 2003, p. 64). Crafted around their agendas; their work is organized to support their interests. Multiple discourses further enhance their position with nurses, society and government and in doing so; these discourses establish connections with unions, the professional association and the government. The public discourse overlooks the hospital’s problems and blames the nurse.
CHAPTER 6: THE RESEARCHER

Returning to the Researcher: Blinded by the Patriarchal Light

This work “must move beyond what the ethnographer already knows or thinks she or he knows, and the ethnographer must be prepared for and open to finding out that matters are not as he or she may have envisaged them” (Smith, 2005, p. 207). Throughout the chapters, I have incorporated my history, field notes and reflections to provide awareness about my feelings and attitudes in the research process (Hall & Stevens, 1991). My interest in understanding the process of nurses working within the conditions of hospitals evolved after I realized that several discourses were structuring the research process. As discussed in an earlier chapter, I began with an interest in stress and the resiliency of nurses working in acute care; however, I found that I was using these discourses to describe nurses and their work. I made many assumptions and in so doing, I failed to understand what was actually occurring with nurses and their work in hospitals. “What we can know and say about our experience is, of course, heavily shaped by requires-the language, discourse, and interpretive framework that are given to us and in which we participate” (McCoy, 2008, p. 705).

After exploring the literature, I became aware of the ideologies and discourses that construct nurses and their work. As I moved into the observations and discussions, their influence on nurses and their work became increasingly more obvious. I did not realize how doing the work of the hospital serves to maintain the nurse’s oppressive place in the hospital. Nurses are “accustomed to adapting their practice to others’ requirements” (Campbell, 2001, p. 232). The analysis revealed how nurses participate and absorb hospital work into their work. The “research stance positions them to discover how
people’s lives are ordered, managed, ruled—to support *interests that are not their own*” (Campbell & Manicom, 1995, p. 12). I realized how deeply embedded patriarchy and nurses’ altruism rule in preserving the hospital’s status quo. “We participate in them without knowing what we are doing” (Smith, 2006, p. 3). Their normative power has been especially enlightening since I too have accepted the hospital’s work as just part of my work as a nurse in acute care. This experience has forever changed my standpoint and social location.

Many uneasy feelings surfaced as I witnessed nurses participating in the ruling of the patriarchal hierarchy. For example, one morning following report, a nurse came to speak to the nurse I was observing. Her voice was filled with emotion as she explained that she was tired of being told to make room for admissions. The nurse went on to say to me, “*We’re always in the middle so we take the crap. The doctors admit and we have to push them [the patients] out*” (FN, 25). She was right. I was astounded at how nurses, including myself, participate in perpetuating the hospital’s power. “From the standpoint within the ruling apparatus, the actual organization of these relations remains unexaminable and disorganized to thought by the conceptual apparatus that constitutes its observability” (Smith, 1987, p. 99). I believed we had to do our work with what we had or more accurately, what we did not have. I believed that my work was secondary to others’ work. I believed that restructuring would improve our work only to learn during the literature review about the research that proved how the restructuring impacted the conditions of nurses’ work (Varcoe & Rodney, 2002). I believed missing my breaks and staying late was expected. I believed that feeling exhausted emotionally and physically at the end of the shift was normal and acceptable. I believed that it was appropriate to lift
patients and laundry bags without the proper equipment. I believed that when patients die you should just get over it. I believed that this was as good as it gets. After all, isn’t that what a good woman had signed up for? Oddly, 20 years later, and many more for some nurses, the same messages prevail.

Strangely, no one explained that we would be working within a structure that still operates much like it did years ago. No one explained how the hospital’s problems would become our problems. No one explained how we would have to continually work short-staffed and still manage the workload. No one explained how budget constraints meant we had to work without adequate nursing staff. No one explained how our excessive salaries contribute to overtime costs. And no one told us that we would be put in situations where we would compromise our patients and ourselves. It is this work that has become embedded in nurses’ work. It is this work that has created sick and fatigued nurses and it is this work that means little within the power of hospitals. “Through all of this and despite much political rhetoric, nursing is still women’s work, performed by a workforce made up largely of women but managed by disproportionately large numbers of men despite positive changes in the last few years” (Hart, 2004, p. 25). Ironically, control and chaos co-exist within the patriarchal structure of acute care.

**Nursing Education: Acute-Care Training**

As the research progressed, I became aware of how my role as a nurse educator supports the institutional discourses and perpetuates patriarchy.

The primary observation that one gains from the analyses is that nursing has totally and irrevocably adopted and incorporated the prevailing ideas of a social hierarchy predicated on occupation, that is, that professions are at the apex of an arbitrary designation of social stratification and hierarchy. (Turkoski, 1995, p. 85)
Admittedly, I have contributed to socializing nursing students in accepting the conditions in hospitals as status quo. “Nurse educators must prepare students to face intransigent bureaucracies bent on cutting costs, and with little or no appreciation of the nurse’s role in making patient care safe and technologies bearable” (Benner, Sutphen, Leonard, & Day, 2010, p. 203). The disconnect between nurses’ education and the real environment is discussed by one nurse as stating “there never seems to be enough time to sit with your patient like you learn in school; that’s just not a reality.” (PI 12)

Because much of students’ clinical education learning experiences are in hospitals, they are quickly socialized to the ruling patriarchy and their role as selfless servers. “She learns about gender roles-that women are to think, speak, behave, and carry themselves differently than men as she aspires to her maternal role” (Boulding, 1991, p. 11). This contributes to maintaining and supporting the hospital’s hierarchal power. For example, during their clinical experiences students know to surrender the chart and space should someone else require them. Students know that they are transient labourers and not employees of the hospitals. “Unlike other apprentices, student nurses are not paid while they learn, although they provide some free labour and incur considerable expenses” (Armstrong, 1993b, p. 41). Students are in hospitals to learn, however, they are also there to work. The units are regularly short-staffed and students are a way to augment the labour gap. “Within the patriarchy, oppression is a reality for women and, for nurses, it is the norm in which they are raised as women and develop as nurses” (Fletcher, 2007, p. 210). I recognize how the students’ labour supports the nurses in reducing their workload yet, actually supports the hospital in normalizing the shortage and the workload as routine.
Many of the nurses involved in my research know me as a nurse educator; during the observations, they would comment on how newly graduated nurses have the book smarts but are not prepared “to hit the ground running.” It is assumed that students can be rolled down the education conveyor belt into the acute-care factory. Sadly, this militaristic mentality “is sustained by patriarchal and organizational discourses which have permeated the way in which nursing practice is configured” (Cheek, 1995, p. 237). Students are expected to transition from the classroom to the hospital. However, newly graduated nurses go through what is described by Boychuk Duchscher (2009) as transition shock which “represents the initial reaction by new nurses to the experience of moving from the protected environment of academia to the unfamiliar and expectant context of professional practice” (p. 1111). Several researchers also discuss newly graduated nurses leaving the profession soon after they graduate (Sochalski, 2002). Sadly, this too, maintains the power in hospitals and constructs nurses as not being able to handle the work.

**Conclusion**

While this research gave me an opportunity to understand how how ruling ideologies and moving discourses are central to controlling nurses and their work, it also made me realize how I contribute to vivifying them. The hospital’s power relations go far beyond nurses and their work in acute care; they can be heard and read within the public discourse. Activated by governments, schools of nursing, regulatory bodies, the union, and myself, they stay alive and insidiously rule nurses and their work in acute care. The next chapter will discuss possibilities and ideas for future research.
CHAPTER 7: IMPLICATIONS AND POSSIBILITIES FOR ANOTHER ONTOLOGY

Where Do We Go to Hear?

“Institutional ethnography maintains a social ontology of the subject based on what people do, how they work, and how this doing and working hooks up with others in a web of ruling” (Walby, 2005, p. 164). In this research, the findings and analysis reveal how nurses and their work in acute care are ruled by embedded patriarchal ideology and multiple institutional discourses. Within these are unseen power relations which shape the work of nurses. Since early days, hospitals have been organized as a ruling hierarchy which relies on nurses’ altruism. Because of the engrained patriarchy in hospitals, nurses are constructed as labourers situated amongst political, economic and societal priorities and agendas. This has resulted in restructuring, incorporating business methodologies, and cost containment strategies which further ignore the actual work of nurses. Thus, a different ontology must be taken up if nurses’ work is going to change in acute care.

A new ontology must begin to understand the realities and acknowledge the actualities of nurses’ work. Before we can realize a new social order, the hierarchy must be acknowledged by government, hospital managers, nurses and the broader community. Nurses’ work must also be understood within the context of moving discourses which will illuminate the actual realities driven by economic ruling. Normative power has aligned nurses’ work with certain conditions; stressors and chaos are only two examples in hospitals. Increasing patient acuity, shortage of staff and overcrowding are routine discourses in hospitals, yet no one discusses how this has become a regular part of nurses’ work except when discussing nurses as stressed, fatigued and overpaid. Nurses
and their work are not confined to the context of acute care, rather they have been conceptualized in various perspectives. Opportunities therefore exist for new beginnings.

The hospital’s social structure does not function in isolation but operates through years of historical influences while attempting to meet contemporary demands. Given history’s stronghold in situating nurses and their work in hospitals, nurses must understand how they participate in maintaining the power of the patriarchy. New knowledge must create awareness and not return to the usual blaming discourse. Nurses and their work are actualized within this context, however their, needs and interests are largely ignored. While it is perhaps too much to believe that breaking down the ruling patriarchy could improve nurses’ work, it is my hope that changes could support their work. Creating a collective awareness about the ruling powers could provide the space for discussion and possibilities for change. The gendered aspect of nursing must also be acknowledge as well as how nurses actively participate in maintaining their place in the hospital. Exposing who holds the power in hospitals also needs to be done. Discussion should also focus on how this power is used. If physicians and other hospital personnel acknowledge how they contribute, perhaps new relations could develop.

This research provides an understanding of how nurses and their work are situated within the discursive construction of acute care. While this research is not provided as another answer to change the conditions in acute care, it recognizes how embedded ideologies rule nurses’ work. At the same time institutional discourses have become part of nurses’ work thus exposing the hospital’s taken-for-granted power. Because of these discoveries, this research provides the evidence to reveal the discursive realities of acute care and how they situate nurses and their work. “The nursing workforce will need to be
wrested away from hierarchal structures predicated on the subordinate role of nursing” (Ward & Berkowitz, 2002, p. 51). While the data provides substantial evidence to identify and unpack the ruling ideologies and discourses influencing nurses and their work, focus groups could also provide a means for nurses to discuss their work.

**Ripping the Bandage OFF the Hospital**

Since early days nurses have been the workhorses of hospitals (Ward & Berkowitz, 2002) and evidence continues to show how nurses’ work in hospitals remains problematic. “The practice of nursing today has been strongly influenced by the historical development of the practice within hierarchical, autocratic, oppressive institutions” (Fletcher, 2006, p. 50). The patriarchal underpinning situates nurses and their work in a quagmire of persistent problems with improvements focusing on nurses rather than on the system. It is no surprise then that this has resulted in the fact that “relatively few hospitals possess favorable nursing practice environments” (Lake & Friese, 2006, p. 8). However, what is surprising is that with all of the research, monies, attention and recommendations given to improve hospitals, an underlying acceptance continues to normalize nurses’ actual work as care of the hospital.

Similar to earlier times, the hospital’s power, along with the same social, political and gender relations, continues to manipulate nurses and their work. “One of the more problematic consequences of the rationalization and cost-cutting of the early-to-mid-1990s was the long-term impact on health care professionals, particularly nurses” (Marchildon & O’Fee, 2007, p. 131). Assumingly, nurses will absorb whatever work is thrown at them which actually means assimilating new patient services without the education, caring for patients in makeshift hallway rooms, managing without resources
during off-peak hours, putting other hospital staff’s needs first, and meeting the business hours of the hospital. Because of this, nurses are doing more of the hospital’s work and getting blamed when things go wrong. Working short-staffed, efficiently discharging, and managing the hospital’s overspending are only a few examples that have been organized as nurses’ normal work.

This “unreasoned acceptance of routinised action that keeps everyone under the illusion that everything we do is on our healthcare institutions makes sense” (Tschudin, 2003, p. 41). Yet today, nurses are charged with even more to contend with in every shift: caring for patients in the hallway; caring for acutely ill patients; working short; and, discharging efficiently. Nurses’ work has moved to care for the hospitals while care of the patients comes second. What will the conditions be like in another decade? We are nurses after all, is that not what selfless, obedient women do while looking the other way? “This has been sustained by patriarchal and organizational discourses which have permeated the way in which nursing practice is configured” (Cheek, 1995, p. 237).

Nurses believe that hospital care is part of their usual work because they have learned how to think and act within the conditions of the hospital. It is these conditions that have shaped their experiences. Oppressed and silently ruled by the hospital, they have come to accept this as their work. “Socialization, the organization of the workload, and the benefits of the current system to those in power maintain this cycle of oppression” (DeMarco & Roberts, 2003, p. 113). Controlled in a structure that exerts unseen power, nurses unknowingly accommodate the hierarchy. Nurses have learned to serve the needs of the hospital. “Leaving the resolution of system failure to individual nurses does nothing to change the traditional medical and nursing authority relationship”
And because they are women, this work is expected. “Nursing practices will always be constrained by more dominant discourse but by recognizing how nursing is discursively constituted the emergence of alternative discourses that value women's work and caring may be facilitated” (Crowe, 2000, p. 966).

In order to do their work in the hospital’s conditions, nurses participate in and contribute to the discourses that rule their practice. Because of this ruling, they have come to absorb the care of the hospital as their work.

Hospitals need an adequate supply of well-prepared, competent RNs to provide patient care, contribute to improving the quality of care, and meet the needs of a growing population of older people, and the nursing profession needs hospitals to provide the resources and environment for its clinicians to practice the art and science of nursing and to obtain income for its members. (Buerhaus, Needleman, Mattke, & Stewart, 2002, p. 130)

Reaching the magic number of nurses in hospitals appeases the union and government agenda, however, it obscures the real issues. As long as the hospital fills its labour needs and meets every societal and political demand on the backs of nurses, they will remain entrenched in a structure that has no understanding for their real work, albeit well-paid work. “But because much of nursing work is invisible, the economic structures do not have to recognize or acknowledge the contribution of nurses in the same way” (Liaschenko, 2002, p. 70).

The time has come to rip the bandage off and notice the discursive structure. Increasing sick time, the growing shortage of nurses, and the increasing exit rate of newly graduated nurses are only a few examples of nurses’ call for change. “Discourses maintain their power through reiteration in practice, therefore a refusal to integrate these into nursing discourse may open up other possibilities for practice” (Crowe, 2000,
Several persisting ideologies and discourses have become normalized in hospitals. They insidiously control nurses and their work. Because of this, nurses adapt their work which unknowingly maintains the hospital’s power. In this study, for example, institutional discourses such as overcrowding, budget pressures and the nursing shortage organize nurses’ work to meet hospitals’ needs. Normative power has resulted in oppressive practices in hospitals. Thus, this work demonstrates how the ideologies and institutional discourses contribute to upholding the nurse’s position in the hospital’s structure.

While this research is focused on urban hospitals, further research could build on this study and identify if similarities exist in rural and community settings. “Taking a wider chronological perspective can help put present problems in a wider perspective and give an opportunity to see long-term trends, change and continuity” (Kirby, 2009, p. 2725).

Healthy Work or Mission Impossible?

Mounting evidence concludes hospital working conditions affect nurses and patients. “There is significant personal injury risk associated with the provision of high-quality healthcare” (Kerr & Mustard, 2007, p. 69). Given the systemic problems in contemporary hospitals, it seems that nurses must risk their health in order to provide quality, safe care. Because of this, nurses are commonly injured and sick time is high. “Although a shortage of nurses to provide care undoubtedly puts the health of all Canadians at risk, the biggest and most commonly overlooked risk is to the health of Canadian nurses” (McIntyre & McDonald, 2010, p. 309). Nurses are placed in situations
where they lack the time, the resources and, appallingly, even the knowledge to care for patients.

Given the work context, it may not be possible for nurses to do their work as prescribed by the hospital and their professional regulatory body. Thus, possibilities for patient and nurse liability issues continue to exist for hospitals. Many nurses believe hospitals ignore this and take no responsibility regarding how they are risking patients and nurses. And, given the hospital’s power, it is easier to blame nurses for its problems. Nurses’ work is largely driven by the needs of the hospital. Unfortunately, this has become a normalized and accepted practice of hospitals.

Rather than caring for patients, managing the hospital’s problems now dominates nurses’ work. “In spite of the high rates of illness and injury, and in spite of their high cost not only to employees but also to employers, there has been very little research done on the health hazards ...and even less done from a gender perspective” (Armstrong et al., 2008, p. 122). Whatever conditions exist, nurses need to understand that compromising their health need not be a normal part of their work. They must question the conditions and expose the risks; policies must be developed to better protect nurses’ health.

Strategies must look beyond serving only the needs of the hospital, governments and other external relations; ideally, they must support nurses in their work. “While reducing staff stress and fatigue through a healing and supportive environment seems like an obvious goal, there are relatively few studies that have dealt with this issue in any detail” (Ulrich & Zimring, 2004, p. 4). Thus, further research could explore how such strategies contribute to patient outcomes.
Shifting Education

Because of nursing’s association with selfless, altruistic ideology, rethinking dominant ideologies and giving more attention to macrosocial and historical influences could provide opportunities for critical discussion about the nurse’s role in supporting patriarchy. History assists in understanding how nurses and their environment have been constructed. This context can provide answers to how such influences embed nursing in a stagnant structure. Nurses need “to know nursing history in the context of gender and oppression to understand social and political dynamics that sustain the status quo, and to understand, and value, female and nursing patterns of knowing and being in the world” (Fletcher, 2007, p. 214). Gender cannot be forgotten. “It would be naïve to assume that ideology will not continue to influence the development of nursing, and that factors such as class and gender relationships, power brokerage, and economics will not continue to reside at the heart of commentary on the nurse.” (Fealy, 2004, p. 655). Nurses must understand the context of where they work: an embedded patriarchal structure organized and coordinated by multiple discourses. Although the conditions in hospitals are widely known, their normative power continues to hold nurses hostage as they accept them as status quo.

Much research substantiates the transition process of newly graduated nurses to acute care (Boychuk Duchscher, 2001, 2009), however, research is lacking on how nursing education shapes students to work in hospitals. “A gap persists between what nurses can do and what they are employed to do, between the education nurses obtain and the work design of hospitals” (Ward & Berkowitz, 2002, p. 42). Nurse educators must engage students to question and not take for granted the status quo in hospitals. Critical
discussion must explore how oppressive situations continue to rule nurses and their work in acute care. Thus, another area for further research could focus on students’ experiences in hospitals as they move through their program.

**Shifting the External Relations**

Since hospitals make changes based on health care spending and political agendas, economic pressures and government priorities inevitably influence nurses and their work. Various solutions have been recommended yet few have been implemented. Understandably, escalating health care costs must be acknowledged, however, the patriarchal power which maintains the business of the hospital must also be acknowledged. The existing traditional structure must be challenged to embark on another way. This new structure would recognize nurses’ unseen work by shifting their participation to a collaborative decision-making team. Different models of care delivery could move nurses to autonomous roles such as patient education, admission and discharge coordinators and patient advocates. Hospitals must shift the power from physicians to a model that incorporates an expanded role for nurses.

**Final Remarks**

A variety of socially constructed terms have become synonymous with nurses and their work in acute care. “Consistently, stressful work environments …have been a mainstay in nursing history” (West et al., 2007, p. 126). Nurses who do not cope with the conditions in hospitals are described as stressed and burned out. When they cope, they are said to be resilient. When nurses work overtime, they are labeled as fatigued. Working excessive overtime labels nurses as money hungry. Such
Ideas produced by a ruling class may dominate and penetrate the social consciousness of the society in general, and thus may effectively control the social process of consciousness in ways that deny expression to the actual experience people have in the working relations of their everyday world. (Smith, 1987, p. 55)

These realities are constructed and mediated by the inherent power. “The institutional foci of the ruling relations is mediated by institutionally designed realities” (Smith, 2005, p. 27). This discourse mistakenly situates nurses as servants who meet the needs of the hospital’s patriarchal hierarchy.

This research shows how nurses and their work are organized and coordinated by the ruling patriarchal relations in hospitals. Patriarchal and altruistic ideologies overlap with the several moving institutional discourses, distorting nurses’ work even further. These discourses intersect with specialized forms of generalizing knowledge that have developed over time (Smith, 1990a). As outlined in chapters four and five, the hierarchy, provincial budget cuts, changing patient demographics, the nursing shortage, and political agendas are only some of the ways that shape nurses and their work in acute care. The analysis reveals how nurses and their work are shaped by the hospital’s power. Years of nurses’ endless compromise and accommodation has resulted in the normalizing of hospital work as their work. Nurses believe that they have to be more efficient and absorb the hospital’s work. This results in routine institutional practices of working short-staffed and meeting the hospital’s business hours and budgetary terms.

Many authors have attempted to articulate nurses’ work in acute care, however, few discuss how they do that work. This research has identified the ideologies and discourses that rule nurses’ work in hospitals. The analysis and discussion explicate how they organize and shape nurses’ work in hospitals. The observations and interviews
reveal how patriarchal values continue to govern hospitals and control nurses’ work. Examples include working around the physician’s schedule and facilitating his work, being efficient as a team, and expediting discharges, to name only a few. Because of the hospital’s insidious power, nurses have come to accept this as part of their everyday work. As long as the patriarchy is maintained and supported, nurses’ power remains less than that of others within the hospital. Nursing work environments remain oppressive while nurses are powerless, exploited by the dominance of medical and business values.

Multiple studies provide evidence suggesting improvements to working conditions yet few are implemented in hospitals. The message is clear that nurses are not valued. What has to change for hospitals, professional associations, unions and researchers to notice? Is it not enough that nurses’ sick time is at an all-time high, is it not enough that nurses are fatigued, is it not enough that patients are dying? In sum, it seems clear that nurses will remain pawns in an environment that notices them only when they cannot serve the needs of the patriarch, cost the system too much or harm someone. Although the political and economic context has changed, nurses and their work remain organized by patriarchal power. Thus, this research further contributes to understanding how gender and social and economic forces continue to rule nurses’ work in contemporary hospitals.

Nurses must realize other possibilities; they must realize that they do not have to become injured, stressed or leave the profession because of the ruling patriarchy. “Through the process of exposing distorted power relations, of affirming women’s lived experience, and affirming women’s consciousness…new language, new meanings, and new social practices, and hence the transformation of social institutions that have been
oppressive” would create change for nurses (Thompson, 1987, p. 27). Re-examining the discourses and the underlying assumptions permeating nurses’ work is necessary to shift the nurse’s place in the hospital. “It is possible to demonstrate where they come from, whose interests they support, how they maintain sovereignty and where they are susceptible to specific pressures for change” (Weedon, 1997, p. 169). While nurses know that they work in the adverse conditions of acute care, they may not understand how they contribute to and are organized to meet institutional demands. Thus, knowing that the hospital is “downloading” work “that requires her to act in a particular way” could provide insight for making changes (Campbell & Gregor, 2002, p. 43).

Ironically, I believe hospitals, governments, professional organizations, unions and nurses aspire to the same goal; yet each works within its own context without realizing the interwoven similarities. My hope is that this research will allow nurses “to see how their everyday work experiences come to happen” (Campbell & Manicom, 1995, p. 5) and contribute to understanding how the insidious patriarchal power rules while gender minimizes the work of nurses. Untangling power will take time, however, if we begin to recognize and name it, nurses’ work has the potential to change.
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APPENDIX A

Research Study Poster
Registered Nurses, are you interested in participating in a research study? The purpose of this study is to understand HOW your work is organized within the hospital setting. To help me understand, I am interested in spending time with you during your shift and interviewing you later.

If you would like to know more, information meetings will be held on (dates and times) in Room XX, or contact me at 775-7638 or at a.m.urban@sasktel.net

Please Note: Your participation is voluntary; you are not required to take part in this research.

Thank you very much.

Ann-Marie Urban, RN
APPENDIX B

Individual Observation Consent Form
Consent Form for Individual Participant Observations

Title of Study: It's All in a Day's Work: Understanding HOW Nurses' Work is Organized in Acute Care

Background: The purpose of this research is to explore how nurses' work is coordinated and organized in acute care. Within the hospital setting, nurses are affected by many factors that influence their work. Although many of these factors are known, many remain unknown. This study, which will explore both, is being conducted by Ann-Marie Urban, RN as part of the requirements for a doctoral dissertation.

Procedure: During phase one of this study, Registered Nurses (RNs) will be observed during their shifts. Nurses will be shadowed over a four- to eight-hour period during approximately ten to twelve different shifts. These observations will help the researcher to understand the social processes involved in organizing nurses’ work in the hospital setting. Individual interviews will be conducted in phase two of the study.

Risks and Benefits: There are no known risks for participating in this study. A nurse’s identity as a participant might be disclosed but her/his confidentiality will be protected by the use of pseudonyms. This study will be performed on different units, serving to decrease the possibility of identification. There will be no direct benefits for nurses participating in this study. Since this study is focused on understanding nurses’ work, the information could assist in organizational change and the improvement of working conditions. Since the observations will take place during nurses’ shifts, patients will inevitably be part of the observations, too. However, while patients are at the core of nurses’ work, they are not the focus of this study and have been purposely excluded from the research process. To maintain their privacy, no patient information will be recorded.

Confidentiality: Information from this study will be kept in confidence. Information will be kept in a locked cupboard and computer files will be password protected with access available only to the researcher. Publications will not include any personal identifying information. As a Registered Nurse and researcher, I am bound to report any knowledge of unsafe practices that could compromise patient safety. If an issue of this nature occurs through the process of the research it will be discussed with the individual and I would encourage the person in question to report the situation.

Voluntary Participation: Participation to be observed is voluntary. The decision whether or not to participate will not affect the nurses’ employment or any relationship with the University of Regina. Nurses are free to refuse to be observed at any time or withdraw at any time without penalty.

Having read the above, I agree to participate in this study and allow Ann-Marie Urban to observe me during my shift. I acknowledge that I have received a copy of this form.

Signature of Manager ___________________________ Signature of Investigator ___________________________ Date ________________

You may contact Dr. Heather Ryan, supervisor at Heather.Ryan@uregina.ca or the RQHR at research&performance@rqhr.ca for verification of this research study.

Ethics Approval:
APPENDIX C

Interview Consent Form
Title of Study: It's All in a Day's Work: Understanding HOW Nurses' Work is Organized in Acute Care

This study is being conducted by Ann-Marie Urban, RN as part of the requirements for a doctoral dissertation.

Please read this form and ask any questions you may have before agreeing to be interviewed.

During phase one of this study, you were observed during your shift. Phase two involves individual interviews in order to ask questions and to clarify my understanding of your work. An interview will be held at your convenience, outside of the hospital and should take no longer than one hour. Interviews will be recorded. You may shut the tape recorder off at any time during the interview. Any personal identifier will be removed from these recordings prior to transcription.

The information obtained in this study will be used for this study only. Any information that could identify you will not be shared with others. The findings from this study may be published, or shared with others in presentations; however, your identity will be kept confidential. There are no anticipated risks to you by participating in this study. There are no direct benefits to you by participating in this study; however, your participation will contribute to further understanding of nurses' work in the hospital. Results from this study could be used to improve nurses’ work environments in Saskatchewan acute care hospitals.

As a voluntary participant in this research, you may withdraw from participation at any time without any direct impact on your work or your relationship with the University of Regina or your employer. No other persons, outside of the researcher, will have access to the knowledge of your participation or withdrawal from this study.

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. Your signature also acknowledges that you have a received a copy of this form.

_____________________________________       _________________________
Participant Signature                                                Date

_____________________________________       _________________________
Researcher Signature                                               Date

You may contact Dr. Heather Ryan, supervisor at Heather.Ryan@uregina.ca or the RQHR at research&performance@rqhr.ca for verification of this research study. You may also verify the ethical approval of this study, or raise any concerns you might have, by contacting the University of Regina or the RQHR.
APPENDIX D

Interview Guide
Part A Clarifying Questions

1. Could you please help me understand why you ____________________?

2. What factors influenced your decision to ____________________________?

3. How does this change your day?

Part B General Questions

1. Can you tell me about a typical day? Night?

2. How does your work change in a day/night? How does ____________(what the participant states) influence your work?

3. How does ______________(what the participant states) organize your work?

4. Describe some of the common challenges you encounter during your shift.

5. How does _________(what the participant states as challenges) influence your work?

6. In the time that you have been working here, what are the changes that you have seen in your work? How has this influenced your work?
APPENDIX E

Letters of Support
Wednesday, November 25, 2009

RE: Research Proposal, Understanding Nurses Work.

To Whom It May Concern:

As the nurse manager of General Surgery, (4D) at the Pasqua Hospital, Ann-Marie Urban has discussed her proposed research on understanding nurse’s work. I support this study and Ms Urban observing nurses during their shift. Ann-Marie will work collaboratively with the nurses during this study and disseminate the findings following the research.

If you have any questions or require more information, please feel free to contact me at (306) 766-2374.

Sincerely,

Blair Broadfoot, RN, BSN.
Manager
Unit 4D
Pasqua Hospital
Regina Qu’Appelle Health Region
January 6, 2010

To Whom It May Concern:

Anne Marie Urban has contacted me and asked permission to conduct observations with the nurses on 3D as part of her research project. I have read her ethics proposal and we have discussed her hypothesis and methods. I am pleased to offer my support for the unit's participation in her research.

Yours truly,

Linda McPhee
Manager, 3D – Internal Medicine
Pasqua Hospital
APPENDIX F

Patient Assignment Sheet
### 3D - INTERNAL MEDICINE

**PATIENT ASSIGNMENT**

**Date:**

<table>
<thead>
<tr>
<th>Time</th>
<th>Charge RN</th>
<th>Rooms</th>
<th>RN/LPN</th>
</tr>
</thead>
<tbody>
<tr>
<td>0730-1947</td>
<td></td>
<td>376 - 380</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>381 - 384</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>385 - 389</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>390 - 394</td>
<td></td>
</tr>
<tr>
<td>1930-0747</td>
<td></td>
<td></td>
<td>Rooms 393, 394</td>
</tr>
<tr>
<td></td>
<td>Rooms</td>
<td>385-89, 390-92</td>
<td></td>
</tr>
<tr>
<td></td>
<td>376-384</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1st coffee 0900, 1400
2nd coffee 0930, 1430 (fifteen minutes)

1st lunch 1130-1200
2nd lunch 1230-1300
1st supper 1645-1715
2nd supper 1800-1830
APPENDIX G

RQHR Policy 601
See related procedure

1. **Policy**
   In all facilities operated under the authority of the Regina Qu’Appelle Health Region, the use of cellular phones, wireless communications devices and other transmitting equipment shall be controlled.

2. **Purpose**
   Regina Qu’Appelle Health Region recognizes that the proliferation of electronic devices in use within the hospital environment poses a potential electromagnetic interference (EMI) risk to medical equipment. Cellular/cordless telephones, wireless computers wireless local area networks & handheld computers (Palm Pilot, Pocket PC, etc.) and two-way radios often employed by hospital personnel are all recognized as potential sources of EMI.

   The Regina Qu’Appelle Health Region will minimize the risk associated with the use of cellular phones, wireless communications devices and other transmitting equipment by limiting the use of EMI generating devices in highly instrumented clinical areas. These areas have medical equipment attached to patients which, if the equipment malfunctions, could cause or contribute to the serious illness, injury or death of the patient.

3. N/A

4. N/A

5. **Revision History**
   Superecede RHD 5.1.6.
APPENDIX H

Overcensus/Hallway Bed Protocol
# Overcensus/Hallway Bed Protocol

**Pasqua Hospital**

Date: _______________  Charge Nurse: ___________________

<table>
<thead>
<tr>
<th>Responsibilities</th>
<th>Time</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review inpatients who may be appropriate/willing to move to hallway/lounge area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review proposed Overcensus admissions with Utilization Coordinator for your service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify specific room # assignment for Overcensus admissions to Utilization Coordinator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service aide to retrieve overcensus bed or Contact Housekeeping Supervisor at 2509 and request Overcensus bed if after 1630</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed delivery on unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determine if additional staffing is required: ☐ Yes ☐ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, contact CSO at 7354</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call sending unit for nurse-to-nurse report for Overcensus admission</td>
<td></td>
<td></td>
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<tr>
<td>Patient arrives on unit</td>
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</tr>
<tr>
<td>Provide patient/family with information &amp; reassurance; reinforce that they will be moved to a room as soon as possible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overcensus patient is transferred to an inpatient room</td>
<td></td>
<td></td>
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<tr>
<td>Contact Housekeeping at 2509 to clean and return Overcensus bed to storage area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete checklist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What worked well?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Suggestions for improvement?

Fax to 4345 – Specialty Care

This form is to be given to your manager when completed
APPENDIX I

RQHR Memos
Memorandum

To: All RQHR Employees

CC: RQRHA Board, Department Head Council, Union Local Presidents

From: Dwight Nelson, President & CEO

Date: March 25, 2010

Subject: Cost of Overtime

Yesterday the Saskatchewan Ministry of Health announced the budget for Regional Health Authorities for the fiscal year beginning April 1, 2010. The Regina Qu’Appelle Health Region (RQHR) has been tasked with reducing operating costs through efficiencies by $11 million, of which over $5 million must come through reduction of wage driven premium (WDP) hours.

Our target for reducing WDP or overtime hours is significantly higher than that set for any other region in the province. The reason for this is because the number (and cost) of overtime hours in this region is much higher than almost anywhere else in the province, and in fact, we are among the leaders nation wide! Being a leader in this category is not something of which we can be proud.

The cost of overtime in the RQHR in 2009/10 will be over $20 million. That equates annually to well over 300 full-time equivalent staff (FTEs). Reaching the $5 million target for reducing overtime translates into a saving of about a quarter of the total, or about 75 FTEs.

Our commitment to you in responding to this year’s budget target is to exhaust all options to reduce costs through efficiency before cutting programs and reducing staff. I ask each and every one of you to work with us and give your commitment to reaching our target reduction in overtime hours.

We understand that there are many factors that contribute to our high use of overtime. Some factors cannot be controlled, especially the fact that we operate largely 24 hours a day, 7 days a week. Scheduling in this environment will require the use of some overtime. However there are many things we can do. The most significant drivers of our overtime experience include:

- replacement for an exceptionally high incidence of sick time and time lost to injury,
- replacement for absence due to vacation and other leaves and inconsistent scheduling practices.

We must reduce our sick time, we must reduce the frequency of injuries to staff and we must improve our scheduling practices.
To meet our target to reduce overtime hours by $5 million in 2010/11 we will:

1. Focus – first and foremost – on things we can do to achieve a healthy workplace, one of our Region’s strategic priorities.
2. Continue to invest in equipment and programs to improve workplace safety;
3. Improve and standardize scheduling practices across the region to minimize scheduling errors and scheduled overtime within the boundaries of our collective agreements;
4. Work with our union locals to find creative collective agreement compliant strategies to reduce overtime;
5. Contract with a physician to validate absences from work that are not substantiated to our satisfaction, and to expedite return to work;
6. Be accountable for providing our managers with the time, operating guidelines, evidence-based data, and tools they need to reduce absence due to illness and injury and to schedule effectively;
7. Ensure that all managers are accountable for the use of overtime and rates of sick leave and time lost injuries on their units/departments; and
8. Ensure that all employees are accountable for attendance and compliance with collective agreement provisions for use of sick leave and overtime.

Success in meeting our target for reduction of overtime hours will not only minimize the potential impact of the budget on job losses and programs, but it will enable us to achieve our goals to improve the patient experience through better patient and staff safety, and reduced wait times for access to our services.

You can expect to hear much more about specific initiatives aimed at meeting our budget targets in the days ahead.

We will work together – collectively and accountably – to ensure we continue to provide safe, quality service to our clients within the resources we have available.

Dwight Nelson

Office of the President and Chief Executive Officer
2180 – 23rd Avenue • Regina • SK • S4S 0A5 • www.rqhealth.ca
Memorandum

To: All RQHR Employees & Physicians

From: Dwight Nelson, President and Chief Executive Officer

Date: May 21, 2010

Subject: 2010-11 Budgetary Measures

On May 26th, the Senior Management Team will present the 2010-11 operating and capital budgets to the Regina Qu’Appelle Regional Health Authority, our governing body, for approval.

This has been one of the more difficult budget preparations we’ve experienced in recent years. The Regina Qu’Appelle Health Region has been tasked with reducing operating costs by $11 million through efficiencies while maintaining current levels of front line care.

We have scrutinized spending at every level in our Region to ensure we are wisely and effectively using our resources while ensuring minimum disruption to our programs and services.

We have identified six key areas where we can reduce costs while minimizing the impact on you, our employees, and on the people we serve. We will accomplish our expenditure reductions by:

- Choosing to delay filling vacant positions that do not relate directly to the provision of front-line patient care;
- Reducing our costs for overtime and for the replacement of employees due to illness, injury or leaves of absence;
- Reducing administrative and travel costs;
- Continuing our long-standing practice of slowing services during the summer months, not only as a cost saving, but to provide you with the opportunity for time off to recharge and spend time with your families;
- Implementing changes to some programs and services, and;
- Limiting in-scope and out-of-scope job reductions to 8.35 full-time equivalent positions. As I indicated to you in April, implementing job reductions was identified as a last option.

We have managed to keep job losses to a minimum this fiscal year as a result of program realignment. It should be noted that during the 2009-2010 fiscal year we increased our approved staffing by 132.
In addition to reducing our expenditures, the Region will generate additional funding through a variety of means, including medical office space rental, parking, and cafeteria revenue.

Over the next few weeks, we will be seeking your ideas on how we can use our resources more effectively and responsibly. We encourage you to offer your ideas for consideration.

Once our Board has formally approved the 2010-11 operating and capital budgets, we will publicly release more details on our funding and expenditures for the current fiscal year.

While we face a challenging year, I know that by working together we can fulfill our commitment to providing safe, quality patient-centred care while balancing our budget.

Dwight Nelson