The Commodification of Caring:
A search for understanding of the impact of the New Zealand health reforms on nursing practice and the nursing profession.

A Journey of the Heart

Jill Fredryce White

VOLUME ONE

A thesis submitted to the University of Adelaide in fulfillment of the requirements for the degree of Doctor of Philosophy in the Department of Clinical Nursing Faculty of Medicine University of Adelaide April, 2004
For Janny and Tom

and

for my Lu
who stayed. Thank God
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APPENDIX I:

Material associated with the research process for this thesis

Information sheet
Consent form
Interview questions
Human ethics approvals
Examples of summaries of group meetings
Examples of N-Vivo Node listings
Examples of N-Vivo models

APPENDIX II:

Supplementary material demonstrating the development of the thinking behind this thesis.

Listing of relevant publications, conference papers and invited addresses within health and education sectors related to the development of this thesis.

Seven papers of particular relevance to the development of the thinking of this thesis:

- Invisibility of nursing in the New Zealand health reforms.
- Managing to care.
- Patterns of knowing – review, critique and update.
- The balance of intuition and research
- Professional doctorates in nursing and midwifery: unwise indulgence or courageous coming of age?
- Health services research: what counts and what is valued.
- Displaying our wares: what do we show, to whom do we show it, and where should we display our wares.
ABSTRACT:

Title: The Commodification of Caring: A search for understanding of the impact of the New Zealand health reforms on nursing practice and the nursing profession.

This thesis seeks to make visible some of the effects on nursing practice and the nursing profession of the political and organisational changes in the New Zealand health reforms in 1995. It seeks to find an answer to the question "what is going on here?" in relation to the nursing profession and its practice from the perspective of an outsider.

My thesis is that political and organisational changes in health care can affect nurses' ability to care for patients. The nurse can experience an intolerable moral tension and the feelings this tension provokes may lead to actions that attempt to ameliorate this moral tension. These actions include leaving nursing, horizontal violence, subversion of authority, taking the "baggage" home and many other forms. The thesis explores personal and professional alternatives to these responses by examining the four major tensions identified in the thesis.

This thesis explores the sustainability of an ethic of care in an environment of managerialism that challenges the fundamental philosophical basis of nursing practice. It suggests implications for practice, policy, research, education and leadership of nursing informed by a feminist ethic of care, one with moral agency.

It may be seen that a consequence of health care re-engineering decisions taken over the past fifteen years in the espoused interests of efficiency and effective healthcare management has resulted in nursing becoming an unintended casualty or "unavoidable collateral damage" of these
"re-forms' (White, 2001). The nurses, in this study, expertly expose this damage. This thesis helps shed light on why nurses' voices were not heard during the reforms, why no one appeared to be listening, the consequence of this to the nursing profession and to healthcare more generally. What we might learn for the future is also explored in order that a nursing ethic of care can be sustained even when we work in an environment in which healthcare is regarded as a commodity.
This work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

I give consent to this copy of my thesis, when deposited in the University Library, being available for loan and photocopying.

Dated: 4.4.04.
Acknowledgements:

I want to thank the nurses and midwives of New Zealand for making me welcome and providing the most extraordinary personal/professional experience of my life and to acknowledge the courage of the nurses in sustaining their caring practices in a time of chaos. I acknowledge and thank particularly the nurses of the hospital in which the action research component of this study took place. I will protect your anonymity by not naming you here but please know how generous your contribution was and how much it was appreciated. Any addition to understanding nursing made by this thesis is shared by you.

I wish to acknowledge and thank also the following people:

The staff and students of the Department of Nursing and Midwifery at Victoria University of Wellington who grew my heart, my brain and my understanding of nursing practice. Rainey Hoggard and Margi Martin, my New Zealand sisters; Jocelyn, Lady Keith, gracious mentor; Cheryle Moss, of the original triad; and George Salmond, who issued a challenge I saw only part way through. This thesis represents a different way of meeting that challenge.

My supervisor, Professor Alan Pearson, for not giving up on me and for generating such a magnificently stimulating doctoral student environment. Thanks also to the fantastic students who shared an all too extended journey.

Professor Jackie Crisp, good friend and critical friend, without whom this work would not have been finished.

Emeritus Professor Donna Diers, writing idol, good friend, who showed by example that it’s always worthwhile.
Grace Lee, wonderful graphic design student and Kay Thorp, Linda Davies and Robyn Willis, thank you for your help with the document. Thanks also to Di Brown and Tony Heywood for your patience with my recent preoccupation.

To Richard, Nick and Ally, who cannot remember when this thesis has not been part of our lives, my love. And acknowledgement also to Dr. Jessie and Dr. Jack who sat at and on my feet as it was written.
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CHAPTER ONE

Introduction

"I Love Nursing But I Hate My Job!"

Losing Heart

International Council of Nurses
Universal symbol of nursing

"The heart shape communicates humanity
and the central place that nursing has in quality health care."

ICN web site www.icn.ch/whiteheart.htm
CHAPTER ONE

Introduction to the Topic:

This thesis seeks to make visible some of the effects on nurses and nursing practice of the political and organisational changes in the New Zealand health reforms in 1995. It seeks to find an answer to the question “what is going on here?” in relation to the nursing profession and its practice from the perspective of an outsider.

I arrived to live in New Zealand in late 1994 as a new professor of nursing to set up the second University graduate nursing and midwifery department in the country. As a relative newcomer to New Zealand I was puzzled to see the state of nursing, having watched it for a decade as an interested Australian outsider, married to a New Zealander and a regular visitor.

New Zealand nursing had been known internationally as forward thinking, strong, robust and influential. New Zealand had after all been the first country to regulate its nursing workforce and the first to give the vote to women. European settlement in New Zealand, unlike in Australia, had always been voluntary for both men and women and a treaty had been struck between the indigenous peoples and the colonial immigrants. There was a dignity and sense of place by right about New Zealand nurses, again in contrast to their more medically dominated Australian counterparts.

When I was first exposed to New Zealand nursing in the mid 1980s, nurses were highly regarded and visible in society. There was a large and senior presence in the Department of Health. New Zealand had been among the first countries to move the education of nurses into the tertiary sector, and nurses were highly vocal on matters to do with healthcare and its requirements. So
why was it that in that on arrival in 1994 I encountered a profession describing itself as tired, emotionally exhausted and dispirited, with only token representation within government, no visible input into the recent health service restructuring, a disempowered union, an almost silent professional voice, a fractured leadership group and experienced nurses leaving nursing saying “I love nursing but I hate my job”?

As a newly appointed professor of nursing, one of only two in the country, I felt an enormous responsibility to New Zealand nurses to try to understand what nursing had experienced, and was experiencing, in order to provide the most appropriate educational programmes and leadership within this bewildering context. As an academic I sought to make intellectual sense of the changed circumstance. New Zealand had recently undergone one of the most radical public sector reforms of any country (Boston, 1991) and so I first explored the political changes, the reforms generally and then specifically the ramifications of these changes for the delivery of healthcare. I looked at what had happened within nursing but I came to see that whilst these explorations had been essential to understanding the context, understanding the life-world of New Zealand nurses at this time would only be possible by accessing the understandings and meanings made by practising clinicians within the work-world. It was only by connecting with the issues of the day-to-day reality of the nurses working within the public health system that I felt I could gain an appropriately deep understanding of the nursing circumstance. My personal journey/study needed to become a collaborative one in order to access understandings beyond my personal experience.

I had been working with one of the recently formed Crown Health Enterprises (CHE, the then new name for the hospital and community services). This CHE, which for reasons of anonymity
will be known as R.H. within this research, had a dynamic leadership group and a publicly espoused commitment to nursing taking a leading role in the reconstitution of care provision. Unlike so many of the other CHEs at the time which were deliberately excluding professional voice for fear of the ubiquitous “provider / professional capture” (Boston, Martin, Pallot & Walsh, 1996, 93), this CHE had several General Managers with health professional backgrounds and a CEO who had managed a social service agency. These people therefore had some understanding of the complexity of the new “business” they were in.

The management team at this CHE described a willingness to engage all staff in the planning for change and sought to determine a long-term vision for the healthcare provision for their community. If nursing could find an engaged way of working within the health reform environment, I believed it could be in this CHE. I felt the understandings of the nurses here could provide an important piece of the larger puzzle and help me understand “what is going on here?” thereby allowing a glimpse of a way forward for nursing.

Researching the professional group I had so recently joined, and whom I assessed as having been through a very difficult time, provided an ethical challenge. If I were to ask something of the nurses it was important to me to give something of value to them in return. An action research process was chosen as its participatory process aimed to involve participants in improving not only the practice, but the understanding of the practice and the practice situation (Carr & Kemmis, 1986).

As a group of twelve nurses and managers we met fortnightly for three months in an action research process to discuss nursing practice and its intersections with management within the
context of this CHE and the broader context of the demands of the health reforms. Interviews were conducted with the individual group members before the action research process to surface issues in order to focus initial group discussion and to gauge the range of perspectives. Follow-up interviews were conducted with some key members following the action cycles for feedback on the process, its outcomes and any changed perspectives.

A modified action research process was used as it most closely reflected a nursing-compatible philosophy by honouring all voices, minimizing power relationships and valuing collective wisdom. It enabled thoughtful reflection on previous conversations, provided safe space in which to surface new issues and enabled conversations to be revisited and deepened meeting to meeting. The group process and the interviews provided a wealth of insight and were described by all to be a valuable process.

The action research interviews and process recordings then became textual “food for thought” for the broader hermeneutic study in which I was engaged. The tape recordings and interviews were transcribed and interpreted by me, moving back from a collaborative to an individual search for meaning.

Time, distance and changed circumstances have meant the “hermeneutic circle” has taken much longer than anticipated to “break” (Gadamer, 1975). The repeated engagement with the text and the continuous movement from part to whole and back again, has enriched the process of meaning making. Because the voices of the nurses have been pulled through time, they are able to both shed light on and be illuminated by the contemporary international nursing literature
about the effects on nursing practice of political and organizational healthcare change in a contemporary 'fusion of horizons' (Gadamer, 1975).

My thesis is that political and organisational changes in healthcare can affect nurses’ ability to care for patients. The nurse can experience an intolerable moral tension and the feelings this tension provokes may lead to actions which attempt to ameliorate this moral tension. These actions include leaving nursing, horizontal violence, subversion of authority, taking the “baggage” home, among many others. This thesis explores the sustainability of an ethic of care in an environment such as one of managerialism which challenges nurses’ fundamental philosophical basis of practice; it explores also the implications for practice, policy, education and leadership of nursing agency in an environment of conflicting ethical positioning.

It may be seen that a consequence of healthcare re-engineering decisions taken over the past fifteen years in the espoused interests of efficiency and effective healthcare management has resulted in nursing becoming an unintended casualty or ‘unavoidable collateral damage’ of these ‘re-forms’ (White, 2001). The nurses through the process recordings of this study expertly exposed this damage. New Public Management principles (Boston, 1991) were applied to a circumstance within health far more complex than the industries in which the theories were first developed, industries where inputs and outcomes were measurable in terms of definable outputs (Easton, 1995). This thesis helps shed light on why nurses’ voices were not heard during the reforms, why no one appeared to be listening and the consequence of this to a profession and to healthcare more generally. And it illuminates what we might learn for the future in order to sustain an ethic of care in an environment in which caring is regarded as a commodity.
My hope also is to provide an acknowledgement of New Zealand nurses and their suffering and courage in continuing to care for patients in a system in chaos.

The Positioning of the Thesis:
This is a nursing thesis. It is written about and on behalf of nursing practice and nursing education for improved practice. It is informed by ideas, methodologies and methods developed within nursing and other disciplines such as sociology, anthropology, philosophy, and education but the lens through which these works are viewed and used is a nursing lens. Ideas from nursing research, policy, politics, management and education are engaged with in order to find meaning in the changed circumstance of nursing practice and patient care.

My positioning within the thesis:
I am a feminist woman, mother, nurse, midwife and academic, and am unable and unwilling to be separated into private and public roles. Each of these aspects of my life influence how I understand the world and choose to work within it. Each provides a fundamental influence on the way in which I construct an understanding of being and knowing and how one comes to know. Explication of these influences will underpin the way in which research methods were employed within this study and how interpretations were formed.

As a woman brought up in rural Australia in a household of women I became sensitised to gender discrimination at an early age. I was profoundly influenced by the fact that it was seen as laughable that I, being a “girl”, should aspire to take over a family sawmilling business. The sense of the injustice of gender discrimination has remained a potent driving force in my life and
has become inclusive of other forms of discrimination such as race, ethnicity, class and any abuse of relations of power.

The mother, nurse and midwife coalesce in an engendered sense of responsibility to care for and about those experiencing a time of vulnerability, to seek to join in a non-hierarchical relationship in which each brings different skills and knowledge to work in partnership towards improved health/growth.

An Australian bush upbringing is starkly gendered but relatively egalitarian in other ways and in the 1950-60s was virtually monocultural. Becoming a nurse in the 1970s in a poor and ethnically diverse area of Sydney I was quickly confronted with the inequities of class and ethnicity and the clear relationships between power and health. By the time this study began in the mid-1990s I had been a nurse for twenty five years, an academic/teacher for fifteen, and a mother for ten years.

Aside from the primary influence of practice there had been some potent influences on my construction of nursing and its teaching. Jean Watson’s (1979) “Nursing: The Philosophy and Science of Caring” and Patricia Benner’s (1984) “From Novice to Expert” had been highly influential. I have always had an intellectual need for frameworks and cognitive scaffolding and Watson’s work connected with my search for a theoretical framework within which to locate my understanding of practice and of what I perceived as missing from the instrumental task mode of practice into which I had been “trained”. I had developed a love for nursing as I saw it practised by skillful and experienced nurses but did not see a connection between this form of practice and nursing as it was taught.
When “Novice to Expert” was published it was as if a gift had been given to senior nurses, those with experience but not necessarily the tertiary education that was now becoming the norm for entry to nursing. These nurses were given a language to explain their lack of language about their practice. It was not this aspect, however, which engaged me most with Patricia Benner’s work. What I loved about Benner’s work was the cognitive map it provided for helping nurses at all stages of education and practice to understand the different ways of being in those different stages. For teachers, it gave a map for helping move students through to a higher level of skill development. The domains of practice provided a further cognitive framing of practice and a greater differentiation of what students could aspire to grasp at different stages of their education. The philosophical positioning of both Watson and Benner in interpretive phenomenology and their critique of “traditional” science as the dominant mode of accessing practice knowledge was a further important influence.

Professor Alan Pearson, first professor of nursing in Australia, lit me up to the primacy of practice, to see nursing as fundamentally a practice discipline and one whose practice was a necessary focus for research (Pearson, 1988, 1992).

Meeting Margi Martin, New Zealand nurse, academic and gifted thinker about practice and its possibilities, was a potent thinking changing/life changing influence. Margi could speak about practice in a way that enabled you to see the whole of it not just the parts. Margi embodied the indivisibility of the person who is the woman/nurse/academic/neighbour in the community. She speaks of “cranking up your thinking” and that is exactly the effect she has on those around her. Margi introduced me to hermeneutics, to Gadamer (1992), and van Manen (1990) (among
countless other things) and engaged with me in many of the conversations that have become this thesis.

Other influences that have shaped my approach to nursing and teaching and thus to this thesis are the work of Stenhouse (1985) and his critique of traditional research approaches for the study of social practices such as education, and I would add, nursing; the extension of this thinking by Donald Schon (1983, 1987) together with his work on reflective practice; the development of Watson’s work into curriculum with Em Bevis on the caring curriculum (Bevis & Watson, 1989); the work of Peggy Chinn (1988) on the theoretical development of thinking about ways of knowing in nursing (based on the work of Carper, 1978); and its extension by me (White, 1995a) to include the sociopolitical ways of knowing as well as the empiric, personal, ethical and aesthetic. I was influenced also by Chinn’s feminist group process work “Peace and Power” (Wheeler & Chinn, 1991), which was to become a central process element in my way of being as a chairperson of a graduate studies department and in this thesis. The writing of Donna Diers was another profound influence, particularly in making visible the invisibility of nursing, (Fagin & Diers, 1983) and in highlighting the importance of practice as the focus of nursing research (Diers, 1979).

Why speak of these people here? They are fundamental to the way I am as a researcher and hence understanding these influences will enable you, the reader, to see more clearly who I am in the thesis and to judge the ontological and epistemological congruence throughout.

I have long held the view that the University holds a sacred place in a society. It is the place where the unspeakable must be spoken and critique, no matter how contrary to the dictum of the
day, must be forthcoming. It is the place for challenging thinking and for permitting the unthinking/rewriting of taken-for-granted assumptions (White, 1995b).

The way in which we worked at the University is also an important background to this research as it displays the way I was known to work with nurses prior to the beginning of the research. In setting up the graduate department of nursing and midwifery at Victoria University of Wellington in 1994 at the time of such distress amongst the nurses of the country, it was imperative that the department became a safe space in which to discuss and explore practice issues. My colleagues and I had a very clear and public philosophy of valuing the practice of nurses (and midwives, but I confine my comments to nursing for the purposes of this work). We taught/learned using a group process which was a modification of the feminist group process developed by Wheeler & Chinn (1991) in their book “Peace and Power”. As the work done in the department inevitably involved discussions of practice and the world of practice, which by the nature of our nursing work is always both rewarding and difficult, we deliberately set up the department to be a place of relief and refuge from the turbulence of the world of practice. We chose to establish a physical environment that was constant. In any teaching room armchairs were organised in a loose circle around a low central table. This table always had on it a candle, rocks representing natural form, water and fresh flowers. This was both a symbol of the stability of the environment and a physical representation of this as a “safe space” for difficult conversations. It also enabled individuals to connect to whatever representations were meaningful to them in the moments in which they needed strength.

A further important consideration was the candle’s link to the international guest at the opening of the department, Professor Jean Watson, who had brought to us a candle with an unbroken link
to the nursing work in many other countries. This description of the department is important here as I was indelibly linked to the department and its ways of working.

Thesis Style and Flow:

This thesis is written predominantly in the first person. It is a hermeneutic study in search of an understanding of what was going on for nursing in 1995 in the midst of the New Zealand health reforms. As such it is my personal construction and therefore it is appropriately expressed in the first person. Where the chapters reflect a piece of academic writing situated within the literature the tone is a more formal one, as in Chapters Three, Four, and Eight. When describing engagement with people, however, the tone becomes more conversational. In the action research component to the study as I am a co-participant in the group process, then appropriately the “I” becomes “we”.

The work is crafted across eight chapters, each picking up the arguments of the previous chapters and growing the story of the work.

Chapter One has introduced the topic, positioned the thesis and myself within the thesis, and addressed the style and flow of the thesis.

Chapter Two sets out the research approach taken by this thesis. It demonstrates the appropriateness for there to be more than a textual reading of the situation and the need for a collaborative component. The action research process is discussed and its congruence with the positioning of the researcher and research exposed. The hermeneutic process of interpretation of the text made accessible through the action research is then explained and the thread of
congruence woven and made visible through rich description, and the laying of a strong audit trail.

Chapters Three and Four are my construction of the context surrounding nursing in 1995. Chapter Three explores the social and political context of the health reforms and the reforms themselves in order to allow an understanding of the way in which the external political landscape impinged on nursing practice. It displays the philosophical underpinning of these reforms, which enables a comparison to be made with the underpinning tenets of nursing.

Chapter Four examines the period of nursing history in New Zealand prior to the 1995 reforms by exploring in turn the changes in education, practice and the industrial and professional circumstance. This chapter builds a picture of independent good intentions that, when taken together at a particular time in history, led to a time of vulnerability for a previously strong profession. I suggest that what happened is not dissimilar to the antecedents of the Perfect Storm, (Junger, 1997) where the outcome is far more calamitous than could ever have been foreseen given its individual elements.

Chapter Five describes the use of an action research process as a methodology for accessing the meaning of the changes to nurses in practice and to nursing practice. This chapter describes the preparation for, and methods used in, the action research component of the study: the study within the study. The participants are introduced and the understanding gained through the interviews with the prospective participants in the group process is discussed.
Chapter Six reports on the group process, which involved meeting seven times to enrich and deepen the conversations between managers and nurses about nursing practice and its possibilities and constraints given the volatile external environment.

Chapter Seven moves back to the hermeneutic search for meaning using the action research recordings as text. The multiple movements from part to whole are described and the interpretation made explicit in a description of the tensions nurses experienced in the midst of the reforms and the actions they were led to take to reduce the moral dissonance they felt.

Chapter Eight explores the ways in which nurses might ameliorate the tension caused by philosophical incompatibilities in a productive way, a way that does not compromise the care received by patients. The aims of action research, according to Carr and Kemmis (1986, 165) are to: “firstly to improve the practice; secondly the improvement of understanding of practice by its practitioners; and thirdly, the improvement in the situation in which the practice takes place”.

This framework of practice, understanding of practice, and the situation in which practice takes place is used as a framework for exploring the changes necessary to nursing and its practice in order to be able to sustain an ethic of care irrespective of the political environment.

A brief after-word then brings us full circle by moving to the present addressing methodology, context, H Hospital and the nursing profession in New Zealand today.

And so to Chapter Two and the development of a map of the research approach - graph of the heart in a journey of the heart.
CHAPTER TWO

Research Approach

A Graph of the Heart

"Every dance is to some greater or lesser extent a kind of fever chart, a graph of the heart"

“I want to make it quite clear that in reporting research I am hoping to persuade you to review your experience critically and then test the research against your critical assessment of your own experience. I am not seeking to claim that research should override your judgement: it should supplement it and enrich it..... I am arguing that it should be subject to critical appraisal by those who have educational (here, I believe Stenhouse's meaning could be extended to 'practitioner') rather than research experience and who are prepared to consider it thoughtfully in light of their experience”

(Stenhouse, in Ruddock & Hopkins 1985, 40)
CHAPTER TWO

Introducing the Research Approach:

In the mid-1990s the turbulent nursing practice environment in New Zealand was causing enormous professional concern and there was a palpable need for capturing and exploring what was happening to nursing practice within the health reforms and the meaning of this for nurses and nursing practice. As the new professor of nursing I was searching for a process that would enable me to make sense of a situation I did not understand, in order to speak publicly for nursing and to teach effectively and positively. This was, therefore, not a circumstance calling for traditional research approaches which require an upfront understanding of the problem and which take considerable time for data collection and analysis before outcomes of the process are accessible. The need for understanding was immediate; so too was the need for the research approach to reflect the way in which I wanted to interact with nurses in my newly adopted country. The research process had to be congruent with my way of being as a feminist woman, mother, nurse, midwife and academic.

The questions themselves and the way one understands the question are the important starting point, not the method as such .... The method one chooses ought to maintain a certain harmony with the deep interests that makes one an educator (or parent or teacher) in the first place (van Manen, 1990, 1-2).

The approach taken in this work reflects a “harmony with the deep interests” that construct me as a feminist woman, mother, nurse, midwife and an academic. Rather than “force fit” a methodology, I have chosen to clearly expose my ontological and epistemological positioning and to then use methods in a manner appropriate to both this positioning and the context of the research. The congruence of the approach will be made explicit throughout the work. This congruence is displayed through the use of rich description and through the laying of a detailed audit trail.
As an academic nurse and teacher of graduate students I have come to see that “off the shelf” methodologies from other disciplines can be helpful in further explicating some aspects of nursing; but for understanding the complexity of nursing practice they are less than ideal. Gaining an understanding of methodological practices is an important part of graduate education but to apply “brand-name” or “off-the-shelf” methodologies directly to practice contexts has the potential to either transgress the tenets of the methodology and/or inadequately capture the richness, the messiness and the paradoxical nature of nursing practice. Janesick (1994) and Harding (1995) share this criticism in their respective work on what they name as “methodolatry”. The greater challenge has been to find another process. The imperative to have three chapters on the history of ideas, the criticism of empirics and the justification of the adherence to one “form” has occupied much space in nursing libraries but has moved the discipline and its practice little. Here I seek to engage deeply in the messiness of the practice situation in a search for understanding and in doing so I take an idiosyncratic path but one which I will show is both credible and philosophically congruent.

Denzin and Lincoln (1994) speak of the qualitative researcher as “bricoleur” – “the jack of all trades or a kind of do-it-yourself person” (1994, 2). The bricoleur, they suggest, constructs a bricolage which is a “pieced-together, close-knit set of practices that provides solutions to problems in a concrete situation….. a complex, dense, reflexive, collage-like creation that represents the researcher’s images, understandings, and interpretations of the world or phénomemon under analysis” (Denzin & Lincoln, 1994, 2-3). Hence, my bricolage:

This thesis is a thoughtful intellectual exploration of a rapidly changing practice situation. It is a personal/professional search for understanding. The thesis begins in 1995 at the peak of the New
Zealand health reforms with a broad hermeneutic study in which the question "what is going on here?" is posed. In order to access intimate accounts of experiences of the reality of the practice world, the study has embedded within it an action research process which is not only illuminating in itself but it also becomes the text for the furthering of the hermeneutic search. The examination of history and context helped give me a framework for some beginning understandings. The illumination of practice issues and the search for meaning within the action research deepened my understanding. The process also helped the participants to better understand the situation of their practice.

The grasp I gained of the situation by the completion of the action research process gave me the confidence to be able to speak widely and to teach as my position demanded, whilst refining my understanding of the reality of the practice environment. It also provided an intellectual space to engage deeply in a prolonged hermeneutic circle of understanding of the circumstances and the consequences for nursing of such radical external change.

In order that you, the reader, can make a judgement about the trustworthiness and authenticity of my work, I detail below the philosophical premises from which I have approached it.

The immediate need for contextual understanding and the later search for deeper meaning are framed within the interpretive work of Hans-Georg Gadamer's (1975) philosophical hermeneutics. An action research component enabled me to access practice understanding of people engaged in everyday patient care, which was fundamental to my quest but not able to be accessed by me directly. The following section lays out first the philosophical positioning of Gadamer, followed by an exposition of my personal perspective and concludes with a
conversation about action research. The congruence of my positioning with both Gadamer’s hermeneutics and action research are exposed throughout.

**Gadamer’s Philosophical Hermeneutics – an understanding of understanding:**

Whilst “hermeneutics” came into modern usage in the seventeenth century, it is not the study of biblical text, the exegesis, with which we are concerned here but rather the hermeneutics transformed into a philosophy of understanding of human sciences by Dilthey, Heidegger and latterly Gadamer and Ricoeur, which is of interest. And it is particularly the work of Gadamer (1975) that informs this study.

Hans-Georg Gadamer in his seminal text “Truth and Method” (1975) laid out his philosophical positioning in relation to understanding within human sciences and strongly critiqued the essentialist nature of knowing that had been typical of the Enlightenment period. Gadamer is concerned with the temporality of interpretation. He suggests “understanding” is always predicated on and informed by our understandings of history and tradition and our previous understandings (pre-judgments); and that any understanding is a product of its context and time. Gadamer sees understanding as foundationally related to language, itself a social construction, as it is one’s pre-understandings or prejudice (pre-judgment) that makes human communication possible. “Actually, ‘prejudice’ means a judgment that is rendered before all the elements that determine a situation have finally been examined” (Gadamer, 1992, 270). It is pre-judgement which enables one to enter into a conversation with text or any human event:

A person trying to understand the text is prepared for it to tell him something. This kind of sensitivity involves neither “neutrality” with respect to content nor the extinction of one’s own fore-meanings and prejudices. The important thing is to be aware of one’s own bias, so that the text can present itself in all its otherness and thus assert its own truth against one’s own fore-meanings (Gadamer, 1992, 269).
Prejudice does not hold the negative connotation for Gadamer that it held in the Enlightenment project. “The fundamental prejudice of the enlightenment is the prejudice against prejudice itself which deprives tradition of its power” (Gadamer, 1975, 239-40).

It is true that interpretation has to start somewhere, but it does not start just anywhere. It is not really a beginning.... The hermeneutical experience always includes the fact that the text to be understood speaks into a situation that is determined by previous opinions. The hermeneutical situation is not a regrettable distortion that affects the purity of understanding, but the condition of its possibility..... Thus the dialectic of question and answer always preceded the dialectic of interpretation. It is what determines understanding as an event (Gadamer, 1992, 472).

Prejudice becomes an entry point, a source for critical self-reflection occasioned by interaction with text in a search for understanding. “Hermeneutic fore-understanding is always at play and therefore requires reflexive enlightenment” (Gadamer, 1992, 555). Gadamer appeals to “critical reason’ for the examination of taken-for-granted assumptions, determining the difference between what he calls legitimate and illegitimate prejudices (1975, 246). Tradition for Gadamer is “historically effected consciousness” (1992), an understanding which is always temporal and changing as it is interpreted from a new point in time with its associated new contextual understandings.

For Gadamer, understanding does not come as a terminal point at which one finds objective knowledge. Rather he works with Heidegger’s ‘hermeneutic circle’ to suggest that one moves around and between sections of a text, from part to whole to part, at each point posing questions to the text, thereby refining understanding. Of the hermeneutic circle Reeder says:

Just as each word is determined by its position in a sentence so each passage and section of the work is to be read in light of the whole. Yet each sentence yields its meaning from the words it contains, and the work as a whole is understood by what each of its various parts presents (Reeder, 1988, 210).
Reeder later suggests the reading of text calls for us to open ourselves to the "newness of what is handed down to us" (1988, 213).

All understanding is interpretation, and all interpretation takes place in the medium of language that allows the object to come into words and yet at the same time the interpreter's own language. Like conversation, interpretation is a circle closed by the dialectic of question and answer (Gadamer, 1992, 389).

By moving between the text and one's own prejudgments one reaches for a "fusion of the horizons" of the text and one's pre-understandings in order to come to a new interpretation. "We regain the concepts of a historical past in such a way that they also include our own comprehension of them" (Gadamer, 1992, 374). This new interpretation is at once understanding, interpretation and application: an interrelatedness described by Gadamer as "one unified whole" (Gadamer, 1992, 308).

In their introduction to "The Interpretive Turn" Hiley, Bohman and Schusterman (1991) explore Gadamer's notion of "application". They suggest the situation that

prestructures interpretation always calls for an application, always demands some response from us in the pursuit of the purposes through which we encounter the situation...What and how we choose to interpret is always guided by motives and needs we carry with the aim of furthering our purpose (1991,12).

Hiley, Bohman and Schusterman see Gadamer's work as related to the Aristotelian phronesis (practical wisdom) and suggest its practical nature is expressed by the fact that it is intentional. It is directed towards something specific; is context bound; applies a particular perspective to that which it interprets, in large part shaping the interpretation; and it is purposive in seeking to further the aim or purpose of the interpretation (Hiley, Bohman & Schusterman, 1991). The practical, applicative nature of this form of study is congruent with the philosophical positioning of nursing as a practice discipline and its gaining of practical wisdom through layer upon layer of

Tradition and prejudice enable new understanding through reading and re-reading the text and forming a new understanding in language which is always the language of the interpreter.

No-one can stage a play, read a poem, or perform a piece of music without understanding the original meaning of the text and presenting it in his reproduction and interpretation. But, similarly, no-one will be able to make a performative interpretation without taking account of that other normative element – the stylistic values of one’s own day – which, whenever the text is brought to sensory appearance, sets limits to the demand for a stylistically correct reproduction (Gadamer, 1992, 310).

The performative interpretation can be enhanced when dealing with text, and reading aloud, Gadamer says, “awakens a text and brings it into new immediacy” (Gadamer, 1992, 399). Gadamer’s philosophical hermeneutics is therefore historical, social, self-reflective and discursive. The aim of Gadamer’s hermeneutics is to reveal a new meaning, one that is projected by the text in interaction with the interpreter. The intention is not to uncover the original intention of the author of the text (Hekman, 1990), but a merging of interpreter and text in the language of the interpreter, time bound and context specific. Gadamer’s work suggests all understanding is therefore contextual, grounded in history/tradition, based in language and with its roots in prejudice/pre-judgment that must be critically examined.

Positioning of Myself as Feminist Woman, Nurse and Researcher:

In Chapter One I spoke of the multiple roles that inseparably constitute who I am and how I understand and act in the world. Since the early 1970s I have named myself a feminist and continue to do so. It was a concept that enabled me to name and frame an understanding of the gendered world I grew up in country Australia. Through the interaction with several generations
of academic writing on the subject I have never subscribed to a particular "brand-name" of feminism, not liberal, socialist, Marxist nor radical, but I see feminism(s) rather as a set of understandings about the way I perceive this society to operate currently and the way in which I choose to be in society. As a woman, I see I have only a gendered way of seeing the world and being seen within it. I will return to this in more detail below.

I have a passionate commitment to connectedness and community. People matter to me and I believe they/we need to be cared for and about. It is unsurprising then that the humanist turn in nursing represented in the work on caring of Watson (1979, 1988) and Benner (1984) with its concernfulness and positive regard for the individual struck an immediate chord with me. My understanding of understanding is influenced by my experience as a student and a teacher and by my studies in a Master of Education programme in which my thesis explored the development of critical thinking within the domain of nursing (White, 1991). I understand understanding to be socially constructed, mediated through language and influenced by history and culture. We come to try to understand something with a "cognitive scaffolding" (Ausubel, Novak & Hanesian, 1978) which enables us to "meet" the text and to then engage with the text in a way in which the cognitive "furniture" is moved around and played with until some understanding is gleaned (Usher, 1985; Usher & Bryant, 1987). The understanding does not come as a terminal event but as an insight for that moment in time, subject to ongoing refinement and change as new experience interacts with old perceptions, as in Gadamer's "fusion of horizons".

Gender, class, culture and personal history all influence the way in which we are prepared to meet the text, an art work, a play or a practice situation. Nursing practice is a stark reminder of one's prejudice, as, in nursing, a nurse interacts with a more diverse group of people under more
vulnerable and difficult circumstances than almost any other social practice in society. These interactions confront one's taken-for-granted assumptions, at times boldly. As Benner so lyrically says:

The nurse-patient relationship is not a uniform, professional blueprint but rather a kaleidoscope of intimacy and distance in some of the most dramatic, poignant and mundane moments of life (Benner, 1984, ixii).

The idiosyncratic feminist perspective or lens through which I view the world and hence this research, is less a theoretical doctrine and more a mindfulness or consciousness; a particular way of orienting to a person or group of people, interacting with them and taking the context into consideration. It suggests not a feminist method but a care in the way in which methods are used (Stanley & Wise, 1983; Harding, 1987; Jayaratne & Stewart, 1991). This mindfulness may be characterised by the following tenets:

- Caring for and about other persons with whom I am engaged (Watson, 1979; Benner, 1984)
- Appreciating that in each interaction each person brings something of value to the interaction, reciprocity, if you will. Being therefore non-hierarchical in engagement (Harding, 1987; Campbell & Bunting, 1991; King, 1994) and ensuring in any research process and reporting that all voices are heard (Keddy, 1992)
- Being self-reflective and critically examining my own taken-for-granted assumptions (reflexivity) (Fonow & Cook, 1991; Harding, 1987)
- Being mindful and particular about process as much as outcome and engaging in an ethical relationship
- Understanding that knowing is always grounded in context: social, political, cultural and historical and being mindful of this contextual positioning of all connection (a dialectical positioning). Where, according to Winter and Munn-Giddings (2002), thinking dialectically requires contextualising what is being said and by whom, and taking into account the personal, institutional and political circumstance or context of its being said.
Whilst not identical, these tenets accord with the four themes Fonow and Cook (1991) identify within feminist research, of “reflexivity, an action orientation, attention to the affective components of research and use of the situation at hand” (Fonow & Cook, 1991, 2). Reflexivity is described by Fonow & Cook (1991) as the tendency to reflect on, critically examine and explore analytically the subject at hand. It moves a step on from reflection to a level of critical analysis. The action orientation is a particularly interesting theme as it encompasses the public and private dimensions, in the case Fonow & Cook are considering, of research. Publicly it addresses the importance of research as “doing something about a situation”, having as an outcome political action or influence on policy. Privately it captures the fact that much feminist research is about intimate aspects of people’s lives and the inherent trespassing aspect of this:

Because much feminist research involves the personal and intimate lives of women and men, any intervention risks the possibility of disturbing relationships that are personally satisfying to the participants and perhaps materially necessary for survival (Fonow & Cook, 1991, 8).

This immediately moves us to the third theme, that of attention to the affective component of research. Fonow and Cook (1991) and Finch (1984) speak of the added ethical responsibility for feminist researchers creating relationships with participants and engaging in intimate conversation as part of the research process. Finch warns that the level of intimacy created can often lead respondents to share information for which they do not clearly understand the “flimsy guarantees of confidentiality” (Finch, 1984, 80). This concern picks up the earlier work of Oakley in her oft-quoted article on interviewing women in which Oakley suggests the need for a sharing of information. Where indeed “interviewing women” is a contradiction in terms as the conversation is non-hierarchical and is an investment of both parties in sharing their personal identity (Oakley, 1981, 41). This engagement with the research participants is congruous with
my being as a nurse committed to engagement with and the “mattering” of the person who is my patient. It is congruent also with my way of being.

The fourth theme suggested by Fonow & Cook is that of the use of the situation at hand. This theme is of particular relevance to nursing research as the practice of nursing in its complexity defies the reduction of its activities to component parts. Researching nursing “in-situ” and “in-vivo” is a research challenge. In this research, whilst we are one layer removed from the practice engagement with patients, we are hearing the nurses’ accounts of their practice in real time within the action research process. It is still a snapshot of the “situation in hand” with all its messy relationships, interactions and constraints.

Jayaratne and Stewart (1991) suggest two additional features to feminist research with which I concur. They suggest that some political analysis is attempted particularly with respect to the implications for policy change, and they subscribe to the dissemination of the research in accessible language and form.

Having exposed my personal philosophy it is not surprising I do not adhere to the position that there should or could be an essentialist feminist or women-centred philosophy, such as that proposed by Daly (1978) in “Gyn/Ecology” or other radical feminists such as Spender (1980). Essentialising women to one mode of being is as oppressive as that which feminism criticises in patriarchal society (Gatens, 1991, 1994). A woman-centred philosophy provides no opening for the new insights, of what Patricia Hill Collins (1991) calls, the “outsider within”. Collins, speaking here of the perspectives brought to the feminist debate by women of colour, proposes
that the outsider within provokes questions that disturb the thinking of the insider and enables a critique to which the insiders themselves are blinded by their immersion (Collins, 1991).

I am not seeking to describe a feminist ontology or epistemology but rather an ontological and epistemological positioning of this feminist. Here I recognise the plurality of views that exist about any social situation. I do not seek to create a male/female binary divide, but rather to capture a values base which embraces subjectivity, contextual messiness and engagement; which challenges taken-for-granted assumptions and becomes deeply embroiled in moving conceptual furniture around. I seek to engage with text, practice acts, experience and historical understandings to the point where one experiences the deliciousness of having one’s “head hurt”. This is the perspective from which this research is conducted.

The relationship between the philosophical hermeneutics of Gadamer and feminism may seem a distant one; however, Hekman (1990, 1994) provides a compelling argument as to the consistency of these two positions. Gadamer’s contextual and historical positioning, his rejection of dualisms, the insistence of language as the medium of social construction of meaning are all consistent with more recent post-modern feminisms, according to Hekman. Gadamer’s attention to explication of prejudices is also consistent:

It follows from his argument that self-understanding entails critique and that self-understanding fostered by feminist analysis is at the same time a critique of the sexist prejudices of our society…. By attacking the dichotomies of Enlightenment thought, Gadamer is attacking an epistemology that has defined women as inferior” (Hekman, 1990, 15-16).

Hermeneutic philosophy, Hekman contends, provides a platform for critique of existing political arguments, a condition of much feminist scholarship. Moira Gatens (1994) echoes Hekman’s concern to see a productive link between philosophy and feminism rather than a dismissal of
philosophy as “dead white men’s thinking”. In her article “The dangers of a woman-centred philosophy” she concludes:

This developing perspective, informed by both feminist theory and philosophy, offers the means of beginning to conceptualize and live – in an intertwined way – other forms of political and ethical being. In particular, a feminist philosophy can offer an integrated, though not closed, conception of being that acknowledges the connections between being and knowing, between politics and ethics and between bodies and minds (Gatens, 1994, 106).

My research, as indicated above, sought an approach that would enable me to access an understanding of the New Zealand situation for nursing in the full force of the health reforms. I had studied both the political and nursing contexts but the piece of the puzzle that eluded me was the understanding of the situation and the experience of the nurse in practice. Given the philosophical position explained above, access to practice understandings had to take place within a particular ethical framework. Practical action research, I believe, is consistent with these principles. In fact the reflective spirals of the action research process seem not dissimilar to the hermeneutic circles, in that they are both reflexive, both dialectical; perhaps therefore action research is the communal version thereof.

The Embedded Action Research Process:

An action research process was chosen to access practical understandings as it enabled exploration through change and was not predicated on capturing data/information in a static mode. It enabled, and indeed demanded, communication between groups of people who were structurally distant from one another’s work-worlds whilst simultaneously within the same work-world, thus providing a vehicle for attempting to gain some shared understanding of "what is going on here?" but from multiple perspectives. It also provided an opportunity for the
participants to look at areas in need of change in process and communication in order to modify and improve practice.

A further advantage of action research in this context is that the outcomes are immediately accessible to the practitioner/participants. In a time of continuous change, there is a need for immediate information, thus enabling practice change and the incorporation into one's understanding of different conceptions of context and circumstance. This contemporaneous understanding and potential for change contrasts with the more usual experience of having to wait for research findings to be published, and encountering the difficulties of dissemination and later incorporation into practice. It returns the benefits of the research immediately to the participants and the workplace. The distributed but sequential nature of the meetings for group work also provides structured thinking time for people whose work environment allows for little such opportunity.

Action research takes place "in social situations which typically involve competing values and complex interactions between different people who are acting on different understandings of their common situation and on the basis of different values about how interactions should be conducted" (Carr & Kemmis, 1986, 180). This is particularly apt for the circumstance of this study where the demands of external forces on the aims and purposes of management were bringing them into potential conflict with the aims and purposes of nursing and nurses.

Although the exact origin of action research is from time to time disputed, it has been known as a distinctive form of inquiry since the early 1940s. Kurt Lewin (1946) is most frequently associated with its origins and its naming, and for proposing it as a means of generating an
understanding of a social situation whilst at the same time trying to change it. For Lewin, action research was a process of circles of planning, action and fact-finding about the outcome of the action. Stephen Kemmis and his associates (1986, 1988) modified this rather stilted process, when action research enjoyed a resurgence as a mode of inquiry in the field of education in the mid-1980s. Lewin's circles became Carr & Kemmis' "self-reflective spiral of cycles of planning, acting, observing and reflecting" (1986, 162) later diagrammatically represented in the now very familiar way by Kemmis & McTaggatt (1988).

The shift at this time is also a philosophical one, with Lewin's work coming from a management and social psychology perspective, whilst Kemmis firmly sites his work within a critical social theory perspective. Emancipation, or the confronting of the oppression embedded in dominant social, political and historical ideologies, is a key objective. This is evidenced throughout the text "Becoming Critical" which Kemmis co-wrote with Carr (1986) and again through the further works with McTaggart (1988) and extended by Reason and his co-writers as Participatory Action Research (2000).

Carr & Kemmis (1986) drew on the work of Shirley Grundy (1982) in which she suggested three types of action research: technical, practical and emancipatory after the knowledge constitutive interests of Habermas (1971). Technical action research seeks to deliver more efficient and effective practice "through the practical skill of the participants" (Grundy, 1982, 357). It is associated with a work place need for practice improvement and is often associated with efficiency gains. This form has direct links to Lewin's work. In contrast, practical action research aims to improve practice through the development of the practical understanding of the participants, in other words the development of a self-reflective community. It treats the
consideration of practice and practices as problematic and open to scrutiny by participants as opposed to holding them as givens or taken-for-granted (Carr & Kemmis, 1986). Grundy’s third mode of action research is emancipatory action research, and its purpose according to Grundy, is “the emancipation of participants in the action from the dictates of compulsions of tradition, precedent, habit, coercion as well as self-deception” (Grundy, 1982, 358).

These classifications have caused me something of a dilemma in relation to this component of the research. The research is predominantly practical in nature and it is, after all, an interpretive study. In working with the participants in an action research process, I did not seek, nor was I given, consent to work in a way designed to transform anything other than understanding. However, inevitably in sound and robust discussion one’s taken-for-granted assumptions are often disrupted and a critique of the political and economic contexts becomes part of the conversation. The action research process then is located as practical action research, exploratory and interpretive in nature but inevitably with transformative moments for the participants that could be seen as small “e” emancipatory. If one were to conceptualise action research modes as on a continuum rather than as discrete entities the action research of this study could be conceived of as practical action research on the cusp of emancipatory but with the transformative impetus focused on the practitioner rather than the system. The “practical” component is the cognitive work undertaken by the participants in articulating their values for practice, challenging them and refining them against the illumination allowed through the expression of contrary ideas by others and returning to the practice context with a different “eye”. This results in seeing the practice circumstance anew and enables the participant to bring this changed understanding back to the next meeting as substance for further discussion. The connection between action research
and the philosophy of Gadamer's hermeneutics can be seen in this quote from Carr & Kemmis (1986):

Educational action research, employing a dialectical view of rationality as socially-constructed and historically-embedded, sets out to locate the actions of the actors in a broader social and historical framework. It treats the actor as the bearer of ideology as well as its 'victim' (1986, 193).

The outcome of an action research process is not a theory or a prescription for action but rather an insight, an interpretation and evaluation within a specific context.

There are two essential aims of all action research: to improve and to involve. Action research aims at improvement in three areas: firstly to improve the practice; secondly the improvement of understanding of the practice by its practitioners; and thirdly, the improvement of the situation in which the practice takes place. The aim of the involvement stands shoulder to shoulder with the aim of improvement. Those involved in the practice being considered are to be involved in the action research process in all its phases of planning, acting, observing and reflecting (Carr & Kemmis, 1986, 165).

The dual emphasis on improvement and involvement creates opportunities for new collaborative relationships between researcher/academic and practitioners and a recognition that the outsider researcher is not necessarily the expert but rather that expertise resides at many levels within and without the organisation or practice setting. This is particularly important in this piece of research as I held researcher expertise, nursing practice expertise and academic expertise but the expertise about practice in this practice situation belonged with the clinicians and the contextual understandings with the managers. It was only through collaboration that all these different forms of knowing could be deconstructed and reconstructed, tested and challenged and new understandings explored.
The Process of Interpretation within Action Research:

With action research the process of interpretation takes place both during the action research meetings and between them. Schon (1983) named this form of internal conversation reflection-in-action and reflection-on-action. This work has been used extensively in nursing and is very familiar to nurses. The forms of intellectual engagement, which are less familiar, but vital to action research of all but the most strictly technical mode, are those of “reflexivity” and “dialectics”. These were discussed above as fundamental processes within research from a feminist perspective. Zeichner (1993) suggested reflexivity and dialectics could be added to Schon’s categories as “reflection about action” ensuring reflection on the social, economic and political contexts of practice as well as on the site of practice, in Zeichner’s case, the classroom.

As part of the ongoing search for understanding in the study participants brought forward for discussion issues or aspects of practice that in some way troubled them. These and the issues that provoked disparate views within the group were the real nub of the action research process for they forced hard thinking about taken-for-granted understandings and brought participants face-to-face with underlying values positions.

By making the meaning of actions transparent to the individuals involved, interpretive social science creates the possibility of practical change in two ways. First, it serves to reduce problems of communication between those whose actions are being interpreted and those to whom interpretive accounts are being made available. For, by showing what is going on in a particular situation, by revealing the ways in which the people in the situation make sense of what they are doing, interpretive accounts facilitate dialogue and communication between interested parties.

Secondly, interpretive social theory may influence practice by influencing the ways in which individual practitioners comprehend themselves and their situation. For an interpretive account, in trying to grasp the sense of individuals lives and actions, may make use of concepts and understandings other than those used by the individuals themselves. It is by providing individuals with an opportunity to reconsider the beliefs and attitudes inherent in their existing ways of thinking, that interpretive social theory can affect practice. Practices are
changed by changing the ways in which they are understood (Carr & Kemmis, 1986, 90-91).

This form of critical reflection is as essential to the form of practical action research used in this study as it is to critical action research. In this study it is the clarification and challenges to ideas of practice that is the substance of the change and hence processes that enable this thought challenge and disruption are the real drivers for movement and change.

Carr and Kemmis remain silent on the reporting of the outcomes or findings of the action research process. Here Susman and Evered (1978) provide guidance. They include a step at the end of the action cycle which they refer to as "specifying learning" or "identifying the general findings" (Susman & Evered, 1978, 588). In this way the process is able to be summarised and findings made explicit to an audience outside the action group.

The Trustworthiness and Authenticity of the Research:

Hermeneutics is by nature an interpretive form of research involving exploration of understanding from the study of text. Inherent in this is the examination of prejudice and tradition – socially constructed, contextual and historical. Action research is by its nature a form of social research. It involves the exploration of meaning amongst a group of people about aspects of socially constructed practices. Both hermeneutics and action research are, therefore, foundationally deeply contextual and notions of objectivity, representative sampling, replicability or generalizability have no relevance for this work.

Distancing, objectification and manipulation of research participants do not rest easily alongside the caring ethic. Feminist research allows freedom and creativity in forging a research partnership with participants to generate knowledge which sheds light on human experience and influences the quality of nursing practice (Carryer, 1995, 186).
The subjectivity and contextuality do not, however, remove the onus on the researcher to engage in research which is "good research practice" and which faithfully represents both the process and the outcomes of the process (Guba & Lincoln, 1994). In fact, quite the contrary. The aim of the action inquiry is improvement of professional practice, improvement in the situation in which the practice occurs, and improvement in understanding both the situation and the practice (Grundy, 1995). It involves a group of people, each of whom has a perspective on the practices under scrutiny, and all voices are seen as equally contributory to greater understanding of the practice and the practice situation. This in no way suggests a coming together to be of one opinion necessarily but a refining of one's own understanding by the interaction with the divergent views of others. Thus in the reporting of the process the voices should be multiple and audible, and the discussion able to be tracked.

As part of the audit trail of this thesis the track for the reader to follow is developed in the following way: In Chapters Three and Four the general context of the research is developed. In Chapter Five the specific context for the action component is vividly painted and the concerns of the participants brought forth through interviews conducted prior to engagement in the action process itself. Chapter Six, then, as its sub-title suggests, gets to the "heart of the matter" and distills the conversations of the group as they progress through their seven two hourly meetings. This is, of course, my interpretation of what should be reported; however, verbatim text records not only the words but also the passion of opinion and the diversity of opinion is shown through tracts of dialogue where appropriate. I also summarised each session and presented the summaries to the group at the beginning of the next session. This was in many ways a very public member-checking as the individual speaking space given to each participant at the beginning of each session enabled dissent or addition to be made to the session summary. The
outcome of this action process does not claim a change in overall practice that would be discernible to an outside eye, but one that was certainly reported as a change in personal practice by the participants. The situation in which the practice occurred, in fact, probably would be seen to have deteriorated throughout and following the action research; a circumstance well outside the control of the participants and largely outside the control of the CHE itself. However, all participants saw the research as a worthwhile endeavour as the change in understanding of the practice and the practice situation was clear. This was articulated by all participants both within the group and privately, even the two participants who left during the process have indicated its powerful effect on them. The personal professional growth through this process has been reinforced in many conversations I have had with the participants in the time that has passed since the group work component.

In Chapter Seven I present a further interpretation of the work of the group following the completion of the group work itself. A detailed description is presented of the interpretive hermeneutic process I then engaged in using the action research interviews and group recordings as text. The outcomes of this hermeneutic deliberation then constitute the remainder of the thesis.

The research approach is diagrammatically represented in Figure 2.1. In this diagram we see the beginning of the process of exploring the context, first of the reforms and then of nursing. The research then enters the action research phase with its reconnaissance, group meetings and the learnings from the process. Following this the research moves back to a solitary hermeneutic process with several cycles of interpretation until finally the hermeneutic circle is broken and this
FIGURE 2.1
OVERVIEW OF THE RESEARCH APPROACH

RESEARCH APPROACH

NEW ZEALAND HEALTH REFORMS

NURSING IN NEW ZEALAND

RECONNAISSANCE

GROUP MEETING 1

GROUP MEETING 2

GROUP MEETING 3

GROUP MEETING 4

GROUP MEETING 5

GROUP MEETING 6

GROUP MEETING 7

LEARNINGS FROM ACTION RESEARCH

N-VIVO ANALYSIS

TENSIONS

BREAKING THE HERMENEUTIC CIRCLE AND LAYING DOWN AN INTERPRETATION
thesis written as an interpretation at this moment in the history of nursing and in my history as the interpreter.

The audit trail is heavily laid. It is rich and thick, and the values underpinning the actions and reflections clearly spelt out. This audit trail attests to the trustworthiness or dependability of the work. (Guba, 1990; Guba & Lincoln, 1989; Denzin & Lincoln, 1994; Koch, 1994; White & Nagy, 1994).

Earlier in this chapter I delineated the principles held within the conduct of the research:

- Caring for and about other persons with whom I am engaged
- Appreciating that in each interaction each person brings something of value to the interaction, reciprocity, if you will. Being therefore non-hierarchical in engagement and ensuring in any research process and its reporting that all voices are heard
- Being self-reflective and critically examining my own taken-for-granted assumptions (reflexivity)
- Being mindful and particular about process as much as outcome and engaging in an ethical relationship.
- Understanding that knowing is always grounded in context: social, political, cultural and historical and being mindful of this contextual positioning of all connection (a dialectical positioning).

The degree to which these are obvious throughout the work is a testament to its authenticity.

The best feminist analysis.... insists that the inquirer her/himself be placed in the same critical place as the overt subject matter, thereby recovering the entire research process for the scrutiny in the results of the research (Harding, 1987, 91)

Mary Ellen Purkis elaborates on this involvement arguing that the researcher's presence is not only inescapable in field studies but that it is their very presence that "underpins the authority" of the work within nursing or any practice discipline (1994, 13). My presence in this whole process
is made quite clear and the subjectivity of the interpretation is an inherent feature of the approach taken.

Transferability, or the ability to see the relevance of this work for other contexts, remains with the reader, as it should with exploratory interpretive work. There is no suggestion that this work is able to be generalized to other situations. The context is richly described such that similarities can be drawn and new ways of thinking tried by the reader as they see connections with their experiences.

Acker, Barry and Esseveld (1991) speak of two qualities that are essential to "good" research. The adequacy of the interpretation - the selection of methods, the manner in which they were employed and the interpretation with the assistance of theory; and adequacy of the findings - do they fairly and accurately reflect what they claim to represent? I believe these questions are ably answered above and throughout the recording of the thesis.

Like nursing practice researching nursing is no "uniform, professional blueprint" (Benner, 1994) or high hard ground but rather swampy lowlands (Schon, 1987) or as Atkinson describes research involving fieldwork: the "actual experience in the field is often messy and fraught" (Atkinson, 1994, 399). Minkin (1997) articulates this phenomenon well when he says "writing involved not the recording of a creative outcome but participation in a further creative process" (Minkin, 1997, 178). I commend this creative process to you and ask that you engage deeply with this text as its story unfolds and interacts with your story in a fusion of horizons.
Figure 2.2 summarises the congruence of the different perspectives used in this study. It takes as its foundation the diagram from Bunting and Campbell (1994, 84), comparing feminist and nursing research and builds upon this. The original contribution of Bunting and Campbell appears in italics in order to clearly differentiate it from my contribution.
Figure 2.2 Comparison of Research Approaches: searching for congruence.

Adapted from Bunting & Campbell, 1994, 84. *(Original in bold and italics)*

<table>
<thead>
<tr>
<th></th>
<th>Nursing Research</th>
<th>Feminist Research</th>
<th>Gadamer's Hermeneutics</th>
<th>Action Research</th>
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<tr>
<td><strong>Epistemology</strong></td>
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<td>Engaged and analytical Women are legitimate creators of knowledge</td>
<td>Hermeneutic</td>
<td>Action research</td>
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<td>Contextual orientation</td>
<td>Understanding by engagement in hermeneutic circle</td>
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<td><strong>Methodology</strong></td>
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<td>Action research</td>
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<td><strong>Purpose</strong></td>
<td><strong>Primary:</strong> Create and validate nursing knowledge as the basis for practice for the good of clients. <strong>Secondary:</strong> Improve political position of profession.</td>
<td><strong>Primary:</strong> Improve women's lives</td>
<td>Providing a human science of understanding</td>
<td>Improvement in the practice, the practice situation and the understanding of the practice situation.</td>
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<td></td>
<td>Making the extraordinary, ordinary</td>
<td><strong>Secondary:</strong> Change social system for good of all humans</td>
<td>Study of life world</td>
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<td><strong>Focus population</strong></td>
<td><strong>Nursing clients or patients</strong></td>
<td>Women</td>
<td>Text, art and human events</td>
<td>Practitioners</td>
</tr>
<tr>
<td><strong>Benefit</strong></td>
<td>Clients/patients, researcher, nursing</td>
<td>Women, researcher, feminism/women’s studies</td>
<td>Interpreter</td>
<td>Nurses and nursing in New Zealand. Participants in the action research study.</td>
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<td>Those interested in new interpretations of the text, art or practice</td>
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<tr>
<td><strong>Relationship between investigator and participant/subject</strong></td>
<td>Hierarchical (less so from constructivist paradigm) Reflection in and on practice Process emphasis Caring orientation</td>
<td>Women/researcher/feminism/women's studies/partnership Reflexivity Process emphasis Caring orientation</td>
<td>Fusion of horizons of this text with its history, and the interpreter with his/her prejudices and traditions.</td>
<td>Process and outcome emphasis Understanding processes leading to desirable outcomes</td>
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<td>Non-hierarchical</td>
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<td>Engaged, reflexive co-creative of text</td>
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<td>Fusion of horizons</td>
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CHAPTER THREE

Public Sector Reform in New Zealand

Tearing the heart out of the public sector.
"When treasury finally gets around to restructuring the human heart"
Cartoon by Tom Scott
Wellington, New Zealand
Reproduced with permission.
CHAPTER THREE

The Historical Context:

Until the 1980s New Zealand had for generations seen itself as a blessed country. Sparsely populated by three and a half million people, on the rim of the South Pacific, green, clean air, mountains that pierce the sky and a society in which people looked after one another in an egalitarian manner. Early social legislation fostered this notion with New Zealand being the first country to grant women's suffrage in 1893. New Zealand was also the first country in the world to regulate its nursing workforce with registration of nurses commencing in 1901. Plunket, New Zealand's family and child health services, looked after mothers and their babies, providing nappies and necessary accoutrements. In 1938 following the difficulties of the depression the Social Security Act, 1938 legislated for a commitment to provide all citizens with free inpatient hospital treatment with access on the basis of need. By 1947 a predominantly taxpayer funded health system had evolved, originally to have been centrally funded, but in the face of the strong opposition from doctors, the profession retained a fee-for-service structure in general practice although this structure was government subsidized (Laugesen & Salmond, 1994; Scott, 2001). Healthcare was a taken-for-granted right of citizenship.

The economic crisis of the 1970s had made governments nervous but by and large the general population saw only “signs of strain” (Gauld, 2001). There was still a sense that all would be well; it was New Zealand after all, “God’s own country”. But with the coming of the fourth Labour government in the mid 1980s the shadows of economic doom had begun to be cast long. There were internal Labour party differences as to the most appropriate models for action but, as history records, the then Minister for Finance, Roger Douglas and the people from Treasury had a cogent plan based on a combination of the latest international economic theories, generally
referred to as a monetarist school of economic thought. It included policies of “macroeconomic restraint and micro-economic restructuring” (Howden-Chapman & Ashton, 1994, 87; Douglas, 1993). Whilst radical, both Douglas and the senior members of Treasury believed it was the necessary “harsh medicine” that New Zealand needed to secure economic viability.

A Theoretically Driven Reform Agenda:
Based on an amalgam of Agency Theory, Public Choice Theory, and what had in the literature been named New Public Management Theory, the hallmarks for the reform of the public sector in New Zealand were determined (Boston, Martin, Pallot & Walsh, 1991 & 1996). Agency Theory heralded the policy framework for corporatisation and privatisation, for changes to employment contracts and performance management; Public Choice Theory emphasized transparency and the separation of policy advice from policy implementation (Boston, Martin, Pallot & Walsh, 1991 & 1996). (The implications of these theoretical frameworks for healthcare will become clearer later in the chapter.)

The features of New Public Management were generally seen as encompassing the following, summarised from Boston et al (1996):

- public and private organisations can, and should, be managed on the same basis;
- a shift in emphasis from process accountability to accountability for results, moving to reliance on quantifiable outputs and outcome measures and performance targets;
- an emphasis on management rather than policy with stress on the generic nature of management;
- devolution of management control coupled with improved reporting, monitoring and accountability mechanisms;
- the disaggregation of large bureaucratic structures into quasi-autonomous agencies including the separation of policy advice from delivery and regulation functions;
• a preference for private ownership, contestable provision, and the contracting out of most publicly funded services;
• a shift to short term and tightly specified contracting;
• the imitation of certain private sector management practices such as the use of short term labour contracts, the development of strategic plans, corporate plans, performance agreements, and mission statements, the development of new information management systems, and a greater concern with corporate image;
• a preference for monetary incentives rather than non-monetary incentives such as ethics, ethos or status; and
• a stress on cost cutting and efficiency.

The radical change in direction from a government of social responsibility for an egalitarian society was noted by Boston (1992). A shift had occurred where human dignity, distributive justice, and social cohesion were starting to take second place to efficiency, budget balancing and the diminution of the public sector (Boston, 1992).

This philosophical shift within government was not an exclusively New Zealand phenomenon and was being played out in the United States, the United Kingdom, the Netherlands and Australia at much the same time, in idiosyncratic ways but with similar goals. (Boston et al, 1991 & 1996; Scott, 1994, 2001; Somjen, 2000; Bloom, 2000). The major differences were in approach, from “Big Bang” to incremental. Initially modelled on Dutch proposals, the New Zealand reforms were seen to most closely resemble the United Kingdom reforms, but also to surpass them in their radical nature (Scott, 2001).

Why is this important to an understanding of changes to nursing practice? Understanding what happened at a society level is essential to contextualising what was happening to healthcare and
hence to nursing. It is this broader level contextualisation that helps to explain the vulnerable position of nursing by the mid 1990s.

This new public management reform was not directed at health specifically; in fact health and education were among the last affected and many people had believed the reforms would stop before touching these two pinnacles of government responsibility. It was a philosophical change in the way government constituted its relationships with public services of whatever kind - this is a point often forgotten by health professionals who felt they bore the brunt of the reforms. The fact that New Zealand had had a large and dominant public sector which had been relatively unchanged since the legislative structures of 1912, may partly explain both the government’s and Treasury’s perception of the need for radical action, the effect on the public and the collective shock at its implementation. The New Zealand public service had had a long history of stability and of career service with long-term perspectives on policy making. By the early 1980s there was a growing belief that the public service had become too large, too slow and unresponsive. Part of the public election campaigning for the Lange team who were to win government in 1984 was an overhaul of the public service (Martin, 1988). Concern related to lack of accountability, effectiveness and efficiency. The language that was to dominate the next decade was already present. The Treasury’s briefing paper entitled “Economic Management” to the incoming 1984 Labour government has become a much-sourced document in tracing the roots of the New Zealand changes, particularly the need for public sector reform. Labour’s first term saw the corporatisation of many of the state assets through the State-Owned Enterprises Act, 1986. The industries affected included coal mining, electricity generation, forestry, postal services, banking and telecommunications. The focus for the Labour government in its second term was the restructuring of management and the hallmarks of these moves are again evident in the Treasury
briefing papers (1987), this time entitled “Government Management”. In order to achieve the desired outcomes two further key Acts were passed: the State Sector Act, 1988 which turned department heads into CEO’s on short-term, performance-based contracts and the Public Finance Act, 1989, which changed forever financial reporting and accountability, shifting from input to outcome measures. In order to monitor these government businesses the Crown Company Monitoring Advisory Unit (CCMAU) was established. With these tools in place the rounds of restructuring began. They continued under successive governments and are only recently slowing.

Health and education were among the last public services to be affected by the reform process and even in the electioneering which led to the change of government in 1990, there was little public discussion which would have alerted voters to the direction which was to follow.

Following the election of the National government in 1990 the reform agenda took an even more solid and ruthless hold. Further enabling legislation was passed as a means of implementing the full competitive market environment. The most important of these for healthcare was the Employment Contracts Act, 1991 which made bargaining rights for workers contestable and basically broke national union representation.

Restructuring Health to 1995/6 – Reforms in full flight:

Within healthcare there was a growing recognition of an impending financial problem. Increasing strains in funding had led in the late 1960s to the introduction of “waiting lists” and an increased public realisation that healthcare was not an ever expanding resource (Howden-Chapman & Ashton, 1994). Private health insurers began to enter the market and through the 1970s private insurance rates grew in NZ, although the private sector never reached any status
beyond that of a complement to the public sector. In the 1970s the Labour government presented a white paper “A Health Service for Aotearoa/ New Zealand” which contained elements of reforms to address cost containment and greater cost effectiveness in the suggestion of regionalisation of health services; however, vocal rejection from the medical profession meant that with the change of government in 1975 the proposals were never implemented (Laugesen & Salmond, 1994).

By the 1980s it had become apparent internationally that healthcare costs were escalating and that the introduction of some system of financial control was an inevitability as the healthcare future was rapidly becoming unsustainable. According to Blank (1994, 25) “Reform efforts in every western nation are to some extent a reaction to three major factors: ageing populations, rapid advances in medical technology, and vastly expanded public expectations and demands”. In New Zealand from 1951 to 1988 the number of people over 60 doubled with a rapid growth projection after 2005 when the baby boomers hit 60. From 13% in 1951 this became 15% in 1988 and will be 26% of the population in 2031 (Blank, 1994).

In 1983 the National government introduced the Area Health Boards Act, 1983 with the amalgamation of local hospitals and health services into fourteen Area Health Boards. These boards were responsible for the provision of healthcare services, health promotion and disease prevention. They were funded by the government to both purchase and provide health services (Laugesen & Salmond, 1994) and were accountable through contracts to the Minister of Health. Of importance to note here is that the Boards had wide responsibilities for “health promotion and disease prevention as well as for the provision of personal treatment and caring services” (Laugesen & Salmond, 1994, 15). However, as had been New Zealand’s pattern, most primary
care was still provided by general practitioners with a government subsidy but also with an escalating user part payment.

The amalgamation of hospitals and healthcare agencies into 14 areas was the first major disruption to the traditional nursing system. Each hospital had had a principal nurse who, together with a general manager and a medical director, formed a triumvirate management team. The amalgamations meant many principal nurses were made redundant and other senior nurses and charge nurses were encouraged into general management. Whilst acknowledged as painful for some, the nursing profession generally was supportive of this more "streamlined" management system as they were increasingly aware of the need for cost minimisation. The loss of senior leadership was, however, quite profound and many very experienced nurses were lost to the profession at this time and in many cases lost to healthcare altogether. The further significance of this move was the disruption it brought to the usual professional communication channels, channels which had been taken for granted for generations.

The formation of Area Health Boards (AHBs) was quite a slow process with some boards not in place until 1989. They were perceived to have difficulties in working out the appropriate balance in their accountability between community and government as each board had a significant number of elected community representatives. With the introduction of the State Sector Act, 1988 the area triumvirate system itself was disestablished and in line with other state owned enterprises a general management structure was introduced. Area Health Boards were expected to formulate strategic and business plans for all services and these were to be used as the basis of contracts between AHBs and the Minister of Health. Before the Area Health Board system was fully in place a task force was set up to review "Health and Related Services". The resulting
report “Unshackling the Hospital” (1988) or, as it was more commonly known, the Gibbs Report, was scathing of the administration of Area Health Boards even though they were in their infancy. It recommended strongly enhanced processes of accountability and the separation of purchaser and provider of healthcare services (Martin, 1991). A further report was commissioned by the Business Round Table from a visiting United States academic, Patricia Danzon (Dazon & Begg, 1991) which laid a path for corporatisation of the health sector with a longer term vision of its privatisation. Both these reports argued that huge savings could be anticipated from such reforms. The recommendations of these two reports were not implemented immediately but contributed to the continued insecurity of the health workforce and may be seen to have sown the seeds of the 1993 reforms when they were announced in July, 1991.

Within an extraordinarily short time frame after coming into power, the new Minister for Health, Simon Upton, released what was to be the blueprint for the most radical healthcare changes. He dismissed the Area Health Boards and replaced them with interim commissioners and released a document “Your Health and the Public Health” referred to by everyone as the “green and white paper” as it had interestingly been printed with half the cover represented by each colour. This was the source of many jokes and may in fact have been a private joke of those commissioning it as community consultation was never seen as an important part of this philosophy for change (Douglas, 1993). Green papers are seen as government discussion papers for wide public consultation, while white papers indicate government policy. The paper was clearly more white than green and indicated that the major structural changes had already been decided upon. Community comment was to be limited to the definition of core services and to the future financing of health including the introduction of user charges to fund health (Upton, 1991, 133). Most of this 1991 green and white document was directly translated into legislation in the Health
and Disability Services Act, 1993 and the intention was to have the system changes in place by the time of the introduction of the legislation, a two-year timetable, 1991 to 1993. Financial imperatives for the government were strong as in 1993 public funds still accounted for over 75% of health expenditure (Howden-Chapman & Ashton, 1994). An early system change was the introduction of part user charges for hospital services which were introduced in 1992 to strong public outcry and disbelief. They were disbanded thirteen months later (Ashton, 1999).

The Health and Disability Services Act, 1993 legislation created four Regional Health Authorities (RHAs) as the purchasers of health and disability services. A separate Public Health Commission was established to purchase public health or population based services. The infrastructure for the purchase of the public health services was never developed and in July 1995 the Public Health Commission (PHC) was abolished. The Ministry of Health, which was to have had no role in purchasing, took over the functions of the PHC (Ashton, 1999). Twenty-three Crown Health Enterprises (CHEs) were created as the major service providers. These CHEs were basically a reconfiguration of the major public hospitals and community services and were to operate along commercial lines. Chief Executive Officers were employed usually from the private sector or from previous experience in running State-Owned Enterprises (SOEs) with only three of the twenty three having any experience in a health-related field.

The core health services, which were to have been the minimum healthcare entitlement for all New Zealanders, were to have been determined by the National Advisory Committee on Core Health and Disability Services, established in 1992. By 1994 it had been determined that a notion of a “list” similar to the much publicised Oregon List was not going to be appropriate and
the committee “reoriented” its activities to providing clinical protocols and evidence based guidelines on specific clinical services.

The legislation contained provision for the development of privately owned Healthcare Plans which would compete with RHAs as purchasers for client groups. Difficulties in risk assessment and the fear of “dumping” high risk groups or conversely “cream skimming” of low risk groups meant these plans were never developed and were eventually shelved (Scott, 1994) leaving the RHAs as regional monopoly purchasers.

But what to purchase, from whom and for how much? Due to an acknowledged lack of information on quantity, quality, use and cost of services, far from exhibiting a competitive approach the RHAs were instructed to “roll-over” the last year’s range and volume of services. By the 1994/5 contracting round the core health services had still not been defined and the RHAs were no closer to knowing what an appropriate cost or volume was. Despite this lack of knowledge and in line with the CCMAU philosophy an adversarial relationship was established between CHEs and RHAs. Gauld (2001, 116) summarises this well with reference to the expressed concerns of the then Health and Disability Commissioner:

The RHAs approached the negotiating table in accordance with the “efficient pricing model” developed by CCMAU, which assumed the CHEs were inefficient and that funding shortfalls would be matched by efficiency gains. There was limited attention given to the quality of services to be purchased, and to the capacity of providers to offer safe services and limit risks to patients.

The relationship between the RHAs and the communities they served was always clouded and communities tended to fall back on old patterns of seeing their local hospital as a place which should meet their needs. This was highlighted by Malcolm and Barnett (1994, 91) thus:
Virtually all CHEs indicated that they identified with a geographically defined population and attached importance to that population's perceptions of their services.... In the same way that CHEs cannot escape the community perception of their responsibility for meeting local needs, CHEs are unable to distance themselves from health status and access issues, properly the responsibility of the RHAs.

Within a relatively short period of the enactment of the reforms, therefore, several key features of the government plan were no longer in place. The real elements enabling competition had been removed and only the rhetoric and the reporting and contracting systems framed for a competitive environment remained.

Within a further year, by December 1996, the Minister for CHEs was reported to have acknowledged that "both clinical staff and the public had raised concerns about the quality of patient care and the heavy workloads" and CCMAU in its briefing to the incoming Minister for CHEs was reported to have said: "Health reforms have yet to yield their original expectations. By a range of measures (e.g. average length of stay, personnel costs, bed numbers) the pace of performance seems, if anything, to have weakened since the advent of the reforms" (cited in Ashton, 1999,143)

The stated objectives of the health reforms heralded in 1991 and legislated for in 1993 were to:

- improve access for all New Zealanders to a health system that is effective, fair and affordable;
- encourage efficiency, flexibility and innovation in service delivery;
- reduce waiting times;
- widen consumer choice of services;
- enhance the working environment for health professionals;
- recognise the importance of the public health effort in preventing illness and injury and in promoting health; and
• increase the sensitivity of the health system to the changing needs of the population (Upton, 1991, 3).

This situation involved a combination of a clearly articulated government philosophy of new public management, processes of reporting to the government through CCMAU in relation to outputs and budgets, but unclear contracting processes with the RHAs, inconsistency in the consequences of under or over shooting contracted procedures where poor performance was often rewarded by a financial hand-out, lack of clarity about the CHE and RHA relationship with their communities and equal lack of clarity about how community engagement and needs assessment were to take place. It is against this backdrop that I worked with a group of nurses and managers in one CHE to try better to understand the realities of work-life and patient care within the health reforms. This provides the important contextual background within which an understanding of nursing in New Zealand in 1995/6 might be framed.
CHAPTER FOUR

Nursing in New Zealand –
legislated into vulnerability

Heartache
“Early morning ICU”, 1994
Photograph by Peter Short
Gift to the author
CHAPTER FOUR

Nurses are feeling battered and bashed and are not moving very fast to take the opportunities under the reforms and that is quite understandable (Gill Grew, Principal Professional Advisor- Nursing, Dept of Health in O’Connor, 1992/3, 27. Emphasis added).

The story we are exploring in this study takes place in New Zealand in 1995. It is a story in search of understanding of the responses of nurses and changes to nursing practice occasioned by the health reforms. However, to make sense or meaning of any human story it is essential to know enough of the context in which the action and responses take place to see the significance of these actions and responses for the characters. In this chapter the context of nursing is explored through an exposition of the educational, practice, professional and industrial changes which culminated in the situation of the nursing profession in 1995. It is reminiscent of the Perfect Storm (Junger, 1997), the serendipitous coming together of several different weather patterns, each in themselves not calamitous but the cumulative effect of which was devastating. Without tracking each of these “weather fronts” for nursing, the circumstance of 1995 seems almost incomprehensible. Each of these changes in education, practice and the professional/industrial environment will be explored in turn so that the cumulative effect will be evident.

Educational Issues and the Consequences for Nursing Research:

The educational issues, which significantly influenced nursing in the mid-nineties, had a nearly 20-year antecedence. The hospital based apprenticeship training of nurses in New Zealand had been criticized from both inside and outside the profession throughout the 1960s (Papps & Kilpatrick, 2002). The Nurses and Midwives Board in 1965 launched a document called a
"Blueprint for Nursing Education in the 1970s" but its recommendations were not taken up by the government. The agitation of the nurses may, however, have influenced the commissioning of a report from a visiting Canadian World Health Organisation (WHO) scholar, Dr Helen Carpenter. The Carpenter Report (1971) recommended the piloting of nursing education programmes located within the tertiary education sector and two pilot programmes opened in Christchurch and Wellington in 1973. Carpenter proposed not more than 20 schools to replace the 53 three year and 54 enrolled or community nurse programmes which existed in 1971. In the report Carpenter drew attention to the need for further education for those who would teach these new programmes as she noted that at the time of the report 39.7% of tutors had a diploma but only 21 of the 343 were enrolled in University programmes (Carpenter, 1971).

It was anticipated that within a decade polytechnic programmes would be the only educational path into nursing and would represent a streamlining and upgrading of nursing education for the country. However, by 1983 only half of the students were being educated in polytechnics and hospitals still “trained” nurses up until 1990 (Papps & Kilpatrick, 2002). For fifteen years nurses were able to be educated in two different systems, delaying the transition well beyond its expected completion. The major outcome of this delay was a prolongation of the divide between “polytech” students and “real” nurses and in 1995, at the time this study began, there was still significant mistrust of nurses educated in the polytechnic system by their hospital trained peers.

The choice of the polytechnic system rather than the university system, whilst allowing a greater geographical spread of programmes, had a major drawback for the profession. Until the Education Amendment Act, 1990 polytechnics were only able to offer awards to the level of Diploma. They became degree granting institutions only after the 1990 Act change. The
expectations for staff to research and publish have always been much lower at diploma level than within the university sector. The impetus for exploring the research base for practice and the expectation that students would be research literate were late in developing. Polytechnic tutors rarely acquired an educational level higher than a degree, as there were only two degree granting nursing programmes available and both required the already registered nurse to gain their degree with little advanced standing. There was limited postgraduate opportunity; until 1994 there was only one University providing access to masters’ degrees and doctorates in nursing and these were not clinical in focus. Postgraduate specialty courses were not available in Universities. By 1989 of 623 nurse tutors in polytechnics, 19% had bachelor degrees and 1.5% had masters degrees (Papps & Kilpatrick, 2002). This left tutors, students and registered nurses with little local scholarship and little “evidence” of the benefits of nursing for health outcomes when called upon in the 1990s to justify their “worth” to the new non-health professional management.

The research that was being undertaken was heavily influenced by the academic interest of the day in interpretive work and critical social theory. Whilst important to the development of the discipline, the research did little to provide answers to the questions being asked by government and health service management of nursing by the mid-1990s: questions such as the cost of nursing care, the effects of differing skill-mix and the effect of nursing care on patient outcomes. Nurses were predominantly interested in researching nursing or the experiences of patients rather than the relationship of care to outcome.

There is no criticism intended here. I believe the profession made every move with the best intentions for the profession. I simply seek to illustrate the consequences of the position by 1995.
The curricula developed within nursing for the polytechnic programmes represented another relevant change. Curriculum development reflected the international discourse about nursing education at the time. There was an emphasis on the need for a theoretical framework for the curriculum (Bevis & Watson, 1989) and on the work of nursing theorists (Meleis, 1984; Chinn, 1983; Chinn & Jacobs, 1987); a focus on primary healthcare and wellness (Newman, Sime & Corcoran-Perry, 1991); a commitment to cultural safety (NCNZ, 1992); an emphasis on the multiple ways of knowing in nursing (Carper, 1978; Jacobs-Kramer & Chinn, 1988); the importance of the nurse-patient relationship (Gadow, 1985; Benner, 1984) and an emphasis on the philosophical basis for nursing as being embedded in an ethic of care (Bishop & Scudder, 1985; Benner & Wrubel, 1989; Watson, 1979).

As one of only two professors of nursing at the time I was called upon to either provide advice to or assess more than half of these polytechnic curricula, so I have a strong personal knowledge of their aspirations, directions and criticisms. There developed a tension between the polytechnic staff and students and the hospital trained nurses, doctors and managers who saw the new programmes as not having sufficient emphasis on the tasks or technical skills required in nursing acutely ill patients. The staff and students wanted to be able to practise in a way that met the wholistic health needs of the patient irrespective of the context and respectful of the cultural background. This may well have fitted the nurse for future practice but in the environment of the mid 1990s the consequence was an education process on a collision course with a work environment progressively focused on efficiency, decreased length of patient stay and acute illness care.
Opening 15 polytechnic programmes led to an exodus of a large number of senior, experienced registered nurses from the clinical area. Many of these nurses had been in leadership positions within the health services. In a small country this loss, whilst necessary for education, was a significant cost to the service area.

The structure of the workforce was also significantly affected by the move of education away from hospitals. Students, who had dominated the workforce, were now supernumerary and the workforce changed from one with a strong hierarchy of authority to a more independent, autonomous, almost all registered nurse workforce. This resulted in a change to many of the support structures in hospitals. Mentoring and in-service education and student services that supported on-the-job learning were seen as no longer necessary by hospitals seeking to save money, and were seen as the responsibility of education rather than health.

**Nursing Practice and the Organisation of Care:**

There had been successive changes to the management and organisation of hospitals for the decade commencing in the early 1980s. The *Area Health Boards Act, 1983* brought the first significant disturbance to the organisation of nursing. The structure of hospital administration had for many years been based on the British tradition of the governing triumvirate of principal nurse/matron, medical director and hospital administrator/manager. Each hospital, irrespective of size, had its own version of this structure. The change to Area Health Boards brought a rationalization of the senior management positions with the disestablishment of the principal nurse positions at smaller hospitals and the formation of an Area Principal Nurse position. Whilst this meant disturbances to many nurses the profession was generally supportive of this
restructuring, as the financial situation of New Zealand had become a significant topic of general and political conversation.

The State Sector Act, 1988 and the Public Finance Act, 1989 created an environment of short-term performance-based contracting for senior managers, including the disestablishment of the government department heads and the creation of chief executive officer (CEO) positions. These CEOs reported directly to the relevant Minister and were responsible for the financial management and financial performance of the “enterprise”. Reporting shifted from inputs to measurable outputs. CEOs were appointed on renewable contracts of up to five year duration. The way in which healthcare was conducted was changing and the short-term nature and the style of the reporting became paramount in the way the hospitals began to conduct their “business”. CEOs were appointed to hospitals and the area triumvirate system was itself disestablished. In restructuring their management system many hospitals moved to clinical directorates devolving budget control including staffing. A further important consequence of this devolution was the loss of nursing control over the hiring, firing and professional development of nursing staff. Many hospitals chose not to appoint a director of nursing and chose instead to have a nurse advisor, with these nurses having no line accountability of nurses to the nurse advisor and the advisor having no direct authority over the nursing staff. The United Kingdom experience of their health reforms had heralded several of these outcomes with the warning at the time from the Royal College of Nursing that the changes to the National Health Service had left the system “stripped of nursing leadership and management” (Dean, 1990,1215) and left nurse managers without real authority.
By the early 1990s it was not uncommon for hospitals to have no formal nursing position above that of charge nurse or nurse ward manager. The effect of these changes on the levels of experience or educational background of nurses is difficult to determine as the decentralisation of responsibility resulted in the cessation of collection of many of the previously recorded databases such as the national health workforce data base. Also centralised planning for the healthcare workforce ceased in the late 1980s. The issue of “commercial sensitivity” often prevented information collation even at an area or regional level.

With the introduction of the Health and Disability Services Act, 1993 and the official commencement of the reforms that had been progressively implemented since Budget night 1991, the Crown Company Monitoring Advisory Unit (known to all as CCMAU) was created to monitor the performance of all Crown Companies including the CHEs. The performance of the CHEs was measured on poorly defined criteria of quality, customer service, public perceptions, operations (length of stay, occupancy etcetera) and their financial performance. “Satisfaction with nurses will be based on three areas – information given by nurses, nurses answering calls, and the courtesy of and attention from nurses... rated as poor, fair, good, excellent or does not apply” (O’Connor, 1993a, 28).

The change to the education system for nurses had major consequences for the organisation of nursing care as mentioned above. The removal of the students as the dominant component of the workforce changed the model of care delivery as it profoundly changed the skill-mix. This was exacerbated by a decision to decrease the enrolled nurse component of the workforce with a steep decrease in the number of enrolled nurses being educated.
New Zealand nursing practice had had a strong historical tie to British nursing but progressively through the late 1980s the influence of changes in practice delivery in the United States were becoming evident. Many of the US ideas were read about in the literature or observed on visits to the States; however, as is so often the trap in “seeing things overseas”, these new ideas were not necessarily imported in a way mindful of the difference in context or mindful of the total package that enabled a new structure to work effectively. This was particularly true of primary nursing (Sunshine & Wright, 1987; Clifford & Horvath, 1990). With a virtually all registered nurse workforce, many senior nurses saw this as an opportunity to introduce primary nursing. However, as generic management progressively took over the running of clinical environments and senior nursing positions were disestablished, many of the key aspects that had made primary nursing an effective practice delivery model, such as communication systems and continuing education, were removed, leaving only an unsupported system of patient allocation. The lack of senior nursing leadership positions and the progressive removal of many of the nursing support roles left the worst rather than the best aspects of “primary nursing”. The potentially isolating nature of patient allocation reduced the sense of team and teamwork.

Primary nursing also assumes a relatively stable and full complement of staff, as familiarity with the environment and its practices and processes is necessary in order to look after a number of patients reasonably independently. By the early 1990s there was growing concern about the level of casualisation of the nursing workforce as the hospitals began to staff for minimum patient numbers and adjust to patient flow through the use of casual staff.

Information to the New Zealand Nurses Association (NZNA) from eleven Areas Health Boards by mid 1993 showed a doubling in the number of casual nurses from 1990, often in specialist
units (Dickson, 1993). “From January 1991 to April 1993 at Auckland hospital the average number of shifts covered by casual nurses a month rose from 154.42 to 937.57” (Dickson, 1993,12). The issues raised by casualisation included the ability of casuals to undertake a “full” workload as casual staff may not know the patients, fellow nurses or ward area, decreased accountability and a decrease in the trust and confidence between patients and nurses (Dickson, 1993). The transaction costs of the administration and orientation and the decreased output of casuals was consistently raised by nurses as an example of false economy.

With a reduction in the full-time establishment numbers in many hospitals, nurses graduating from polytechnic programmes were finding employment difficult to obtain, with up to 50% of new graduates without employment in NZ hospitals within a year of graduation (Williams, 1991). The tight job market made job security an issue of growing importance for nurses and the nurses’ professional journal at the time records a concern by nurses about speaking out regarding unsafe practice for fear of losing their jobs.

Job security is a real issue. Many are afraid to speak to nurse managers, as they don’t want to be seen as a stirrer or troublemaker. And there is a real power imbalance between staff and managers. Many nurses are in “survivor mode”. Their workloads mean they are very busy and very stressed. This means they are internally focused and haven’t got the energy to look outwards (O’Connor, 1992, 15).

CHEs had written into the nurses’ contracts that nurses were not permitted to speak publicly about the CHE or its work. Public statements were only permitted through their media offices. “Speaking-out” became a significant dilemma for nurses who saw themselves as patient advocates but were effectively gagged when witnessing sub-optimal care provision (O’Connor, 1992).
By the formal commencement of the reforms in July 1993, the nurses' journal was reporting nurses “have(ing) experienced dizzyingly frequent management changes in their workplaces”, “members have been hit with so much change the latest round is like water off a duck's back” and descriptions of nurses as “cynical” about the new reforms bringing improvements. (O'Connor, 1993b, 20).

Whilst the legislative changes were in many ways detrimental to nursing practice they did create opportunities. Midwives and Maori nurses grabbed the opportunities and capitalised on the ability to contract for services and work outside the traditional conceptions of service within a hospital. The Nurses Amendment Act, 1990 enabled midwifery to again become a separate discipline to nursing and radically changed the relationships between midwives, doctors and nurses (Pairman, 2002). For nursing, however, the numbers were so large and their work so much more institutionally bound, that nurses in hospital based practice, in particular, felt the full force of the changes of the health reforms.

Professional and Industrial Changes:

For many decades nursing leadership had been provided through a close network of relationships between the Division of Nursing in the Department of Health, the nursing professional body, the New Zealand Nurses Association (NZNA), and the Matrons’ Association. The Division of Nursing controlled service, education and regulatory aspects of the profession. The Nurses Act 1971 created an independent New Zealand Nursing Council and removed the regulatory aspects from the Division and introduced the experimental polytechnic programmes, effectively transferring the control of nursing education from Health to Education portfolios. The Division was large and powerful through the 1960s and 1970s but with the deprofessionalisation of all
government departments as part of government policy through the mid to late 1980s, nursing’s influence in the Department of Health was to shrink to purely a policy advisory role occupied by a single person.

The NZNA was progressively occupied by the increased demands of an environment that sought deregulation of all labour groups, culminating in the introduction of the Employment Contracts Act, 1991. This Act removed compulsory unionism and prohibited multi-employer contracts that meant that NZNA had to bargain separately with each Area Health Board or subsequent Crown Health Enterprise on behalf of any nurse still choosing to use them as their industrial agent. There were significant consequences of the ECA for nursing. The negotiations were extremely time and resource consuming for NZNA and the nurses involved, conditions of work were able to be eroded and the gap in earnings between men and women during this time widened (Harmond & Harbridge, 1993). The environment was one of protracted industrial disputes and strikes and of increasing insecurity for staff with rising unemployment and senior staff on individual short-term contracts. By July 1993 over 120 separate contracts covered nurses working in the private and public sector in New Zealand whereas previous to the ECA there had been eight (O’Connor, 1993c). New Zealand industrial relations academic Pat Walsh (1992) said of the ECA that it introduced industrial stability through coercion, isolated workers and left no room for equity concerns. Its focus, according to Walsh, was on enhancing the vulnerability of the workers.

The Employment Contracts Act was seen as so detrimental to the conditions of nurses’ work that the International Council of Nurses (ICN) at its congress in Spain in 1993 passed a motion condemning the Act. In New Zealand the Catholic Bishops were moved to describe the Act as treating:
...human labour as a mere commodity regulated by the principle of supply and demand and (it) encourages individual bargaining to the detriment of the duty to act in solidarity (Smithies in Slater, 1996, 12).

An unexpected side effect of the concentration of NZNA on industrial matters was that there was a perceived vacuum of comment on professional matters and a growing body of nurses was calling for the establishment of a professional college of nursing. The NZNA, unsurprisingly, resisted this and in the early 1990s, at the time of the discussions about starting a college, the NZNA amalgamated with a smaller union the NZNU (Nurses Union) to become the NZNO, the New Zealand Nurses Organisation, publicly stating this as being in the interests of having a single voice speaking for nursing.

Aside from whether another ‘professional voice’ is needed in nursing, the timing of this proposal is not good. The public health service has just been shredded (again) and nurses need more than ever to have a strong united voice, rather than splinter themselves further” (Stodart, 1991, 2).

In 1992 a professional college was established called the “College of Nurses, Aoteaoroa”. In 1994 the very senior and experienced executive director retired from NZNO and was replaced by a very much more industrially focused head. The separation became progressively clear that that the professional voice came from the College and the industrial voice from the NZNO. There were many issues on which these organisations held differing opinions.

The once powerful Matrons’ Association had undergone several name changes as frequently as the various restructurings came and went but by the early 1990s this was a very disempowered group. Its membership varied enormously in levels of authority and seniority as it was the most senior nurse in any CHE who attended. There were occasions where a CHE was not represented at all as it was not clear who spoke for nursing in that institution.
All this change was taking place against the backdrop of a profession which had recognized for some time its relative invisibility to outsiders.

**The Invisibility of Nursing Work in Accounting for Healthcare:**

The invisibility of the work of nurses – together with the undervaluing of the physical and emotional labour of caring has been widely written about in nursing for a number of years now, (James, 1992; Fagin & Diers, 1983; Smith, 1991; Parkin, 1995).

Nurses as trusted peers are those who hear secrets, especially the ones born of vulnerability, nurses are treasured when these interchanges are successful, but most often people don't wish to remember their vulnerability and their loss of control, and nurses are indelibly identified with those terrible personal times (Fagan & Diers, 1983, 116).

Women's work and its invisibility was comprehensively addressed by Marilyn Waring in her 1988 book "Counting For Nothing - What Men Value and what Women are Worth". Here Waring draws attention to what is valued, what counts in terms of national and international accounting.

I learned that in the United Nations system of national accounts, the things that I valued most in this Country - its pollution free environment, its mountain streams, its safe drinking water etc counted for nothing, they were not accounted for in the private consumption expenditure, the general government expenditure or the gross domestic capital formation, yet these accounting systems were used to determine all public policy since the environment effectively counted for nothing, there was no value on policy measures that would ensure it's preservation.... Hand in hand with the dismissal of the environment came the evidence of the severe invisibility of women and women's work (Waring, 1988, 1).

Whilst Waring does not ever speak directly about nursing, it is possible to see the parallels. When accounting for healthcare, the number of operations can be counted, the number of days in hospital can be counted, the number of pharmaceuticals dispensed can be counted, the number of tasks performed can be counted. More difficult to count and hence account for is the emotional care and intelligent exercise of clinical judgement provided by nurses as they appear to be
undertaking predominantly physical tasks. The high level of clinical judgement is disguised behind the use of common and colloquial language and the friendly engagement. In New Zealand this invisibility was compounded by the lack of audibility as the nurses were silenced from public comment by their employment contracts, in which speaking about company business was sufficient grounds for dismissal.

The Cumulative Effect:

This period was characterized by rapid-fire legislative changes. Specifically these were: The Area Health Boards Act, 1983; The State Owned Enterprises Act (1986); The Commerce Act (1986); The State Sector Act, 1988; The Public Finance Act, 1989; The Education Amendment Act, 1990; The Nurses Amendment Act, 1990; The Employment Contracts Act, 1991; The Mental Health (Compulsory Assessment Treatment) Act (1992) and The Health and Disability Services Act, 1993. Together with individual professional decisions that were appropriate at the time, these legislative changes culminated, in the mid 1990s, in a professional group whose members were experiencing extreme change fatigue, who had little visible formal leadership, whose professional organisation was only in its infancy, whose once strong association/ organisation was acting primarily as an industrial union, and who were represented by only one nursing position in government. When naively I asked Alison Dixon, a very articulate, passionate nurse, why senior nurses did not appear engaged with the changes she responded: “We’re submished out. The sense of disillusionment is profound. I’ve never felt so lacking in elastic. I think we’re exhausted” - a poignant statement capturing years of trying to make a difference and having less and less speaking space in which to do so.

In the Nurses’ Journal in May, 1992 Jocelyn Keith, past Executive Director of NZNA, nurse academic and practitioner summed up the effects of the health reforms on nursing as:

fragmentation and anxiety being produced by yet more changes in the service. For the public, this has meant fear and uncertainty: the promise of more choice is no comfort. For nursing, this has meant a loss of ‘esprit de corps’, the loss of new graduates, maybe even a whole generation of nurses. We are all becoming very tired (Keith & Peach, 1992,13).
Margaretta Styles (1982) in her book "On Nursing --Towards a new endowment" suggested for nursing to make its full and appropriate contribution there needed to be:

- expertise of practitioners
- recognition and support from the public
- an enabling political, economic and legal climate and
- the ability of the profession to maintain unity whilst appreciating diversity.

The climate described above and in Chapter Three suggests, therefore, conditions far from ideal for nursing to make a productive contribution. This then was the educational, practice, professional and industrial environment in which the study was conducted.
CHAPTER FIVE

The Action Research Process

Understanding through collaboration

Getting to the heart of the matter
CHAPTER FIVE

The context of the radical reforms that New Zealand had experienced from the mid-1980s to the mid-1990s and the consequences for nursing were explored in Chapters Three and Four. This exploration provided an important backgrounder to nursing and nursing practice at the zenith of the reforms in 1995 but still did not allow access to what it was like to be a nurse working within the public health system at this time. An action research process was chosen as a means of accessing an understanding of the complexity and messy nature of practice and the changes to the way in which nursing was practised within the constraints of the new environment.

In this chapter the process aspects of the action research component of the study are described, together with the interviews conducted prior to the commencement of the group work. These highlight the concerns of the participants prior to their interaction. It was very important to me that the process was consistent not only with the principles of action research itself, but that these were enacted in a manner consistent with the way in which I chose to interact with nurses in the research. Therefore, I chose a way that is non-hierarchical, honouring of all the voices of the participants, working within a safe speaking space, communicating in a warm and conversational environment, engaged in a reflexive and dialectical mode (Carr & Kemmis, 1986; Kemmis & McTagggart, 1988; together with the feminist writers already referred to in Chapter Two).

The action research process will be unfolded by looking in turn at the nature of the problem, the change and the context; a reconnaissance – examining the concerns of the participants prior to becoming a group; forming a critical community; setting up and keeping safe space; and concluding the research without finishing the conversation or disrupting new relationships. For
me, the process was to enable me to have an ‘eye’ into the practice issues that I could not otherwise access from my academic position. Taking a staff position was not an option. Philosophically I believed the privilege of this personal access had to be balanced with at least an equal gain to the participants. The action research process was therefore set up with an explicit aim that related to improvement in practice and practice understanding for all participants. This enabled both my specific needs to be met but in a way that was also a valuable and valued process for the participants.

The Nature of the Problem, the Change and the Context:

The problem at heart was seen as a disjunction between the perceived goals, work processes and language of the management of the Crown Health Enterprise (CHE) reflecting the managerialist approach of government, and the goals, commitments and language of nurses; and the perception by all concerned that if there could be better alignment of goals and their expression then the outcome would be better. There was a lack of clarity as to “better” for whom: the “company”, the nurses, the “patient”, or all three.

The action research process aim, as described in the information sheet to prospective participants, was “to facilitate shared understandings between management and nursing of the difficulties and opportunities of the ‘reformed’ health service”, such that nursing could take advantage of the opportunities and be part of shaping these changes.

The title of the project at that time was declarative of the philosophical positions that were seen to be at odds. The working title was “The commodification of caring, sustaining a nursing ethic of
care in an environment of managerialism in the aftermath of the health reforms in New Zealand”.

The information sheet for prospective participants also helps set the study context thus:

As you are well aware the health "reforms" in New Zealand have led to many changes, including increased emphasis on accountability, outcome measures, performance indicators and competitive contracting. This new environment has changed nursing practice and will continue to do so. Nurses appreciate and live daily with the costs of these changes but they also have the capacity to contribute to shaping the future of New Zealand healthcare. Change is inevitable. Nursing can either choose to be part of change or be buffeted by the decisions of others.

Conversely healthcare organisations are extremely dependent on nurses and nursing practice for patient/customer satisfaction and with the implementation of change processes. This study aims to facilitate shared understandings between management and nursing of the difficulties and the opportunities of the "reformed" health system (Information sheet - Appendix I).

The particular CHE, chosen as the site for this study was somewhat atypical as indicated in Chapter One. It had two managers with health professional backgrounds and an espoused respect for the importance of nursing in the success of its mission. I had worked with the management of this CHE on the recruitment of expert nurses to be part of their change process as Clinical Nurse Specialists, and I had worked with nurses throughout the CHE on several professional development activities. I was known and believed myself to be trusted as much as any “outsider” and had had informal discussions about the idea of the action research process with managers and with staff nurses and several other groupings which would traditionally have been seen as mid-hierarchy. It did appear that if positive cultural change for nursing and its aspirations for improved patient care could work at this time in the midst of the reforms it could be here.

And “here” was a CHE with a 400 bed hospital in the outer suburbs of a large metropolitan area. It had a well-defined community that saw the CHE as its local hospital and a stable long-term nursing staff who declared and displayed great loyalty to the hospital and the community it
served. The community also had access to a tertiary 1300 bed hospital in the city centre, which the community had seen as providing complementary services, but which the reforms had constructed as a competitor organisation.

R.H., the name given to our CHE for the purposes of the research, had 1200 full-time equivalent staff members, a total revenue 1993/94 of $66m and a total asset base in 1994 of $40m. This compares to its neighboring CHE with over 3000 staff, 1993/94 revenue of over $200m and 1994 assets of $175m. Relative to this neighbour therefore R.H. was staff rich and asset poor, having one third of the beds, nearly half of the staff but a fifth of the assets of its “competitor” CHE (Management, 1994, 45).

There was a relatively new management team at R.H., which had been in place for approximately eighteen months, consisting of a CEO and six general managers, each with named portfolios. Collectively they were known as the Executive Management Team (EMT). Two of the general managers had health professional backgrounds, most unusual at that time as previously stated. The clinical environments within the hospital had been broken up into a new management structure introduced five months before the study began. The internal structure was a form of clinical streaming referred to as a “service team” model. Each consisted of a management triumvirate of Clinical Nurse Specialist, Resource Manager and Medical Director as the joint heads of each service team; but there was no clear sense of lines of authority and leadership within the teams. There were, however, clear divisions between each of the service teams, such that “borrowing” staff or equipment required requisition and repayment as each service team was seen as an independent cost centre. This introduced a way of working which was very foreign to the espoused culture of the staff as a community, as one hospital.
The Participants and the Nature of the Relationships within the Group:

My aim in this research clearly was to understand and to learn, as a nurse, an academic and a researcher. I came to this study with the ontological and epistemological positioning described in Chapter Two, that of feminist woman, Australian and recent newcomer to New Zealand, nurse, academic, Chairperson of the local University Department of Nursing and Midwifery and Professor of Nursing.

I was strongly associated with this university department and the philosophy we espoused and the way in which we worked. When involved with the nurses at this hospital I had routinely brought with me the symbols synonymous with the department as described earlier, of rocks, water and light as a representation of safe space, hard talk and nursing’s global commitment to improving health and patient care.

I was speaking regularly throughout the country about nursing and had done so many times at this hospital to broad audiences. I had worked on specific staff development programmes with nurses at the hospital and several had been students of the university department I chaired. I had worked with management on senior nurse recruitment and provided advice on management issues. Some form of relationship had therefore been established with the majority of the people who were to become part of the action research process. I thus regarded myself as an engaged participant in this process rather than an outsider/observer.

Initially it was hoped that the group would be heterogeneous in terms of gender, position and patient care context, not for reasons of representation or ‘sampling’, but rather for the diversity of the conversation. There were to be four staff nurses but the one male approached was unable to
commit to the time requested, so there were three staff nurses, all of whom were female but who came from different areas across the hospital. One of these nurses left the hospital towards the end of the study. There were four Clinical Nurse Specialists (CNS), clinical and administrative leaders in the new structure, one of whom left the hospital midway through the research. All the CNSs in the hospital were female.

The most senior nursing position in the hospital was the coordinator of nursing professional career development. The position had no line accountability or authority but was seen by the nurses to be a disempowered principal Nurse/Director of Nursing position. The nurse who held this job agreed to participate.

There were three Resource Managers in the study, two of whom had nursing backgrounds, and one of whom was male. Two General Managers had agreed to take part, one of whom declined the day before the process was to begin due to “pressure of time”. We were thus a group of twelve on day one, reduced to ten by the end of the action research process.

Despite best attempts at diversity we were ten females and two males and the males were both non-nurses in management positions. This was not an atypical picture of the healthcare environment but it did mean that as a group we had to be mindful of the mixing or collapsing of gender issues and management issues, again not an uncommon situation in healthcare. We were mindful of equality in speaking opportunities and of not allowing any particular voices to dominate the group conversations.
The realities of engaging in such an action study inevitably include the possibility of changes to the group of participants across the time of the study and also the possibility of some participants not being able to be present at every group meeting. However, I was both impressed and humbled by the priority the participants gave to the meetings given their heavy work/life commitments and very few participants missed any of the sessions and no-one missed more than one.

**Introducing the People in the Study:**

The participants will be introduced in their employment groups of staff nurses, CNSs, resource managers, and senior managers. The people in the study were invited to choose pseudonyms, most did so and a couple indicated they were happy for me to choose a name for them. They are represented here by their pseudonyms but with some personal detail so that you, the reader, can gain some sense of who they are as people as they enter the group work.

**The Staff Nurses:**

**Colleen** is a very experienced nurse in a specialty area. She has a passionate commitment to “kind and supportive patient care” (Interview C1) and whilst she has worked for nine years at this particular hospital, she said she had taken little notice of the management changes or the health reforms more generally. Colleen’s primary focus is the pre and postoperative care, dressings and pain relief for her patients and communication with their families. Colleen was hospital trained and has been nursing for over twenty-five years. She had decided that the way to cope with the constant management changes was just to put her head down and concentrate on providing each patient with the best care she could give but has recently become more interested in finding out “what is going on here?”
Wendy works in the area of inpatient psychiatric nursing and has worked in the position for nine months prior to the group work, having previously worked in community mental health. She has been at this hospital for 3 years. Wendy believes that patients with mental health problems are poorly served by hospitals at the best of times but fears for the clients in an environment which "is supposed to make a profit" (Interview W1). Wendy has had experiences with clients who have needed to be hospitalized for long periods of time on expensive medications but who are eventually discharged well and who lead productive healthy lives and she worries about whether this long-term care will continue to be available in the "new health system". She raised the issue of the shortsighted nature of "costing" episodes of care as they fail to take account of the true cost/benefit to society such as the cost effectiveness of someone ceasing to be chronically ill and having many years of being a productive member of society. Wendy joined the research to gain a greater understanding of "how management thinks" and to have an opportunity to "let them know about mental health".

Sandra has worked at R.H. for 18 months and works on a medical ward. She says the past six months have been constant change with a completely new management group and says there have been "ups and downs" in the changes. One of the aspects of the ward that she has been shocked by is the negative, "anti-management" view openly expressed by the nurses. She is surprised by how ill-informed some staff and patients are about the health reform and general public service changes in New Zealand. Sandra is an experienced nurse, having worked in many other New Zealand hospitals and overseas. Sandra joined the group as she felt strongly that "people need to hear what nurses are feeling like here" (Interview S1).
The Clinical Nurse Specialists:

The clinical nurse specialists had been appointed by R.H. only six to nine months prior to the research, having been carefully selected by the CHE for their interest in nursing taking a strong role in the future development of R.H.. I had been part of the interview process and so was well aware of the expectations they held of their positions and what they believed the CHE expected of them. An important aspect of their appointment was their attitude to further education and all were either enrolled in or had completed tertiary nursing study. They were well versed in the international literature of the day on the management and leadership for nursing practice development.

Harriet is the CNS of one of the specialist surgical services. She has nursed for over twenty years and has had experience as a charge nurse and a unit manager controlling staffing and budgets. She is greatly saddened by the removal of Principal Nurses / Directors of Nursing as she saw them as pivotal to professional development and a sense of professional community. Harriet believes strongly in the need for senior nurses to be role models for professional collaboration. “My main concern with the health reforms was that with competition you were going to lose cooperation and collaboration. With competition you get inequality” (Interview H1).

Nina is the CNS of a specialist surgical service and has only been at R.H. since the new structure was implemented. She has recently returned from living overseas where she had been developing community based health services and has not worked in a hospital for over ten years. She has been impressed by the opportunity for nursing involvement in the redevelopment of the health
services at R.H. and the fact that management espoused the critical nature of nursing input into the new governance processes. Nina believes nurses need to be nurtured themselves in order to be able to provide the nurturing care needed by patients and that abuse or burnout of nurses has a direct and negative impact on the quality of patient care.

Olga is the CNS for the aged care area and is passionate about the quality of patient care. She sees the reforms as providing great opportunities for nurses to be more influential and to take to management their understanding of what constitutes quality patient care. Olga is distressed that the "caring component is not being at all valued and not recognised" as she considers this an essential component of Total Quality Management (TQM) to which she is committed. "I see humanistic caring and TQM so aligned." (Interview O1)

The fourth CNS, Katrina, announced in the opening round of Group Two that she had resigned from her position. Her input was therefore not included in the reporting of the study.

The Resource Managers:

Robyn is the resource manager in maternity services. She has a nursing background and had been a practising nurse up until four years ago. She became a manager as she saw the nursing structure being "pulled down, devalued and eroded" and she saw "nowhere to go career wise" (Interview R1). The removal of the senior nursing structure of the principal nurse, supervisors and charge nurses "left us down at the workplace feeling really vulnerable and out on a limb basically... The senior nurses were like fence posts, I suppose – the solid bits always there to refer to" (Interview R1). Robyn believes a consequence of the new structure is that nursing has become parochial, fragmented and shortsighted. "They only see their world as being their
ward and don’t see across the other side of the hospital” (Interview R1). Robyn is not a midwife and believes this provides clearer boundaries than if she were a resource manager in an area of her nursing expertise. Robyn enjoys “holding the purse-strings” and the staff having to justify what they want for practice as it makes them “think out loud” about their practice.

Mary too had a background in nursing before becoming a manager. She speaks candidly of the difficulties of the transition at first. She said when making a decision she would first put on a nursing hat and then a manager’s hat and then argue with herself. It took eighteen months for the transition and she now makes decisions as a manager informed by her nursing understanding. Mary has been at the hospital for three years and is the resource manager for a general surgical ward.

Patrick is the resource manager for the critical care areas. He does not have a nursing background but has worked in the health industry for seven years in mental health and public health areas. Prior to this he had worked in hotel management. Nurses and nursing are still somewhat of an enigma to Patrick who says no two nurses ever present nursing as the same thing or in the same way. He believes that in his seven years in health he has seen nurses become significantly more professional and less likely to act as doctors’ handmaidens. Patrick sees senior management as having very little to do with nurses on a day-to-day basis. Only when there has been a poor customer satisfaction survey does management get involved with the nursing staff in which case

the message will come down for the nurse to pull their socks up...but not once have they come down and said what can we do about this together. (Interview P1).

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The Senior Managers:

Colin had been a doctor but has been in health services management for seven or eight years prior to taking up general manager’s position. Colin had been the general manager who had appointed all the CNSs and was the most familiar with their expectations of their positions. As a general manager Colin is a member of the EMT (Executive Management Team).

Dawn was employed a relatively short time prior to the study to develop a professional clinical career pathway for nurses. She had worked in the neighbouring CHE prior to coming to R.H.. She is a graduate of the polytechnic system of nursing education and has become a quite senior figure relatively quickly. None of the CNSs is a polytechnic graduate; however, two of the staff nurses are. Dawn is not considered part of EMT but rather sits to the side of the formal structure but is clearly seen by the nurses to be the senior nursing figure.

In introducing the participants individually I have sought to construct a fuller picture of who entered the room for the group meetings. You will not hear from them individually again as I have taken the decision that the costs of exposure, of owning the quotations, is greater than the benefit of attribution. When the transcripts were read thoroughly it became apparent that the contribution made to the conversations was clearly related to position more than person and that the study lost nothing in identification by position rather than person. The individual contribution is honoured by honouring their group position fully.

Forming The Critical Community:

The major aim of action research is the establishment of conditions under which self-reflection is genuinely possible: conditions under which aims and claims can be tested, under which practice can be regarded strategically and
"experimentally", and under which practitioners can organise as a critical community committed to the improvement of their work and their understanding of it (Kemmis et al, 1982, 6).

Having had informal chats with management, senior nurses and a selection of staff nurses about the idea for this project and modifying my original ideas as suggestions were made, I took the role of participant/researcher/facilitator and wrote up the study proposal for both management agreement and ethics approval. This approval was obtained from the Regional Health Authority Ethics Committee, my own university and the university at which I was enrolled as a doctoral student (see Appendix 1).

The same ethical considerations had to be explored as with other forms of research. These included the duty of care to protect the well-being of others, protection from harm, respecting of rights, preserving confidentiality, ensuring informed consent and the right to withdraw participation at any time, and publication protocols (See Appendix I for information sheet and consent form).

Of particular importance in action research is the reassurance of the voluntary nature of the participation, confidentiality of what is said in the group and the ground rules of equity of participation (explored in more detail under "setting up and holding safe space" below). Permission was sought to interview each participant prior to the group work, and to tape-record this interview and the group interactions. Permission was extended to the use of these transcripts for further analysis at the conclusion of the group work. The individual interviews were taped and a transcript returned to the participants prior to commencing the group work. This was intended to provide an impetus for the participant to start thinking about the issues that would form the discussion in the group. It also provided me with an idea of some of the most
contentious or dissonant issues for prompting critical conversation in the group work. It was a form of reconnaissance work quite usual in action research and is explored in the next section in detail.

The venue chosen for the group work was a setting to which no-one in the group otherwise regularly came. It was a tutorial room in the medical school annex. This was seen as appropriate as it was not regarded as any group member’s territory; was a space of learning; had an eclectic collection of old armchairs and a kitchenette attached to the room, which provided a sense of a space for conversation. The room was within the grounds of the hospital so participants were able to easily access it and the usual issues such as parking did not arise. I quite purposefully set the room up with the same artefacts as I used at the university, as described above, and supplied good coffee and tea and inviting finger food for each meeting. This was seen as part of honouring the contribution of the group members to take on this extra commitment and also was seen as a physiological necessity for those who came straight from the wards. The sessions were held 6.30-8.30pm every second Tuesday for a three-month period.

In the three months immediately prior to the commencement of the group sessions the interviews took place in order to capture the individual concerns.

The Reconnaissance – the concerns of the participants:

Reconnaissance may now seem a dated term with military connotations that reflect the immediate postwar genesis of action research (Grundy, 1995, Kemmis & McTaggart, 1988). The visual association of flying low over the ground to see the “lie of the land” still has merit however. It is a strong metaphor for taking a good look at the environment prior to the beginning of the first
action phase of the first action research cycle. Kemmis & McTaggart (1988) suggest it is similar to the phase of reflection which precedes each new action cycle but obviously the reflection-on-action is not possible until the first cycle has at least begun, hence the need for a pre-action phase – the reconnaissance.

In this study the reconnaissance may be seen as a fly-over at two altitudes. There is a high level fly-over which provides an understanding of the political environment of the health system at the time (already discussed in Chapter Three) and an assessment of the professional nursing environment within which the nursing practice of the time took place (discussed in detail in Chapter Four). The more low-level and detailed reconnaissance is focused on the concerns of the people of the study before they enter their work together, presented here.

As a participant in the study, I needed to provide a reflexive account of my own positioning (described in Chapters One and Two). And each of the other participants required a vehicle for exploring their positioning. This was achieved through individual unstructured interviews with me which took place in the three months immediately preceding the group work.

I had sent all participants a sheet of “starter” questions for them to think about prior to the interview and I took a second copy along for them to peruse immediately before starting the interview. I told all participants clearly that it was not a list of questions that they had to work through and answer but that they could use it as a guide to the conversation. The interviews were conducted with just the two of us present in a location of their choosing. These venues ranged from hospital wards to coffee shops but irrespective of the surroundings they were constructed as
informal comfortable “chats” with the interview questions provided only as a broad map of the territory to be covered.

When reading the transcripts of the interviews it became apparent that there was homogeneity in the way the members of the each category of staff answered the questions, and a difference between categories of staff with the exception of those I had originally grouped as “senior managers”. The responses of the senior manager who was not a nurse were quite akin to those of the resource managers. This similarity held regardless of whether the resource manager had been a nurse or not. The senior manager who was a nurse spoke very clearly as a nurse and her responses were more closely aligned to the responses of the CNSs. I therefore decided to group the interviews into three categories of staff nurses, senior nurses (CNSs and the senior nurse) and managers. This not only collapsed the categories but also had the advantage of protecting the two senior managers whose responses may have been easily recognised and their anonymity compromised.

The three groups answered the questions with distinctly different emphases. The staff nurses focused on staffing, lack of understanding of nursing practice by management, nurses as buffers for patients against the extremes of the hospital changes, the appearance of false economy, and the lack of appreciation of their work. The senior nurses shared the staff nurses concerns over staffing and resourcing of nursing practice and the lack of acknowledgement of nursing’s contribution by management. They also spoke of leadership/management, a broad concept of healthcare that included the community, the way in which nursing care was measured or was valued, and the effects of the reforms on nursing practice.
The managers spoke of their high regard for the contribution of nurses, their understanding that nurses were frustrated by their conditions of work, particularly where related to constant change and lack of resources. Common to their responses was a surprise that nursing was not more proactive in moving their practice forward and a sense that nursing was a “key” to improved health service delivery. The difference in the ethical frameworks for resource allocation between nurses and managers began to appear. A strong theme of their responses related to the highly political nature of the reforms.

It was as if their foci were like concentric rings around the patient with the staff nurses closest to the patient, the managers furthest away linking to the external environment and the senior nurses occupying the in-between position spanning the practice and the management. This is represented diagrammatically in Figure 5.1. This is not in itself surprising but it was surprising how clearly this was reflected in the way they each chose to answer a fairly broad set of questions.

The Voicing of their Concerns:

The following dialogue provides examples of these concerns in the words of the participants and captures some of the passion with which the sentiments were expressed:

The Staff Nurses’ Concern:

On staffing and lack of understanding of nursing practice by management:

*We're not here to glorify management or to bow down and worship our Clinical Nurse Specialist. We're really here to provide the care that patients deserve in a public health sector.*

*I often wonder if they actually know what goes on in the wards... some of these management people should just come over and just trail along behind a nurse just for a day, a shift, and just see what it's actually like; the on the spot decision-making
that you have to make all the time; the physical work of nurses when the ward is busy...... just coping with the staff shortages. Managing on what you've got, using equipment that's old, the lot of it, just lots of things. Doctors making decisions about drugs that we haven't got so a patient can't have it because it's too expensive or the hospital doesn't buy them because it exceeds the ward budget.

We've had our bed numbers reduced to lessen the stress on the budget. So that's been quite hard having reduced bed numbers but still having clients that need to come in and having to go above that set number, back up to what we were, but still trying to run with the number of staff we were given for reduced numbers. So that's been difficult. Trying to find staff and also, perhaps, feeling like maybe we should manage on the lower number of staff when we really do need an extra person, but other times if you haven't called someone in you can have pretty hair-raising situations where you needed an extra person.

It's difficult for us because often, you know, all the clients come in and we get extra staff in but they maybe casual staff who we haven't worked with before. It was quite hard especially as a lot of them hadn't had (relevant) experience. So we were faced with quite high acuity levels which was why we were calling the staff in but having the staff who weren't familiar with the area ....the patients' medication etc, so in some ways it was harder on us because we had someone who didn't know the ward or the clientele or the area. And if we call in someone from an agency that is more money, ..........we were basically told only to use agency staff if absolutely necessary.

Speaking of a particular area where use of casual staff is extremely difficult:

You can't just come along and do a dressing on someone or prepare them for an operation - it's a "therapeutic use of self", you have to use yourself to gain a rapport with the person and work with them and enable them to just take time out, some of them need a lot of time just to get themselves together, whether it's to get over a manic phase or just to calm them, just to allow the medication to work. You're using a lot of different skills, it's not just your training, it's your life experience as well, bringing a lot of different areas into what you do with the person.

Nurse as buffer for the patient from the extremes of the health reforms:

I think nurses are actually quite good at hiding things that are going on, you know, external factors that are affecting their work, like health reforms, whatever, money, rosters, budgets, you know, stuff like that.

Yeah, we're sort of the meat in the sandwich. We sort of take it (any restriction on care) to the patient but we take it in a really nice way... I think it would be fairly unprofessional to walk up to the bedside of a patient and start raving on
about the health reforms, I really do. I think it's inappropriate and it's not really what nurses are here for.

We moan and groan sometimes about it but we carry on and we do it and, and in the end the patient gets good care. There can be a whole lot of crap flying around in the background and the patient wouldn't know it was there because the upfront person at the end of the bed or the side of the bed is the nurse who's just doing the same old thing in a way, but in another way not doing the same old thing. Just caring for that person and encouraging them and planning their care and all that sort of stuff so - But that's a good thing I guess.

And on the issue of false economy:

They've basically got rid of the old Charge Nurse who did the budgets and the rosters and all the other stuff and they made it into, into basically two jobs - the Clinical Nurse Specialist and the Resource Manager. Now I mean it sounds like the Resource Manager does a lot more than just the budgets. They're going for funding from the RHA and lots of other things in their job description but people ....see that the one person was replaced with two people, so...where's all the money coming from? And why isn't it going into patient care or equipment or getting the waiting lists down. That's a very simplistic view of the whole thing but that's how a lot of nurses see it.

The R.H. had just had two very public expenditures that infuriated nurses. The CEO was paid a very handsome bonus, which was reported in the press, and three senior CHE managers went on an extensive trip to United States and United Kingdom hospitals. At one level the nurses saw this might have a longer-term benefit but when faced with daily staff shortages and tight budgets they found it difficult to reconcile:

But nurses are very here and now people...I mean most nurses would be interested in doing stuff that would benefit the patient. They're not interested in doing stuff that would benefit the management.

These large expenditures were juxtaposed against the restriction on small items that directly affected the quality of the experience of patients:

Like the Milo would run out and that's maybe a small thing, but to a client who can't sleep perhaps, and just wants to make a Milo, saying sorry, you've got to wait to next week, it's run out. Or washing powder, that type of thing.
FIGURE 5.1
THE CONCERNS EXPRESSED IN THE INTERVIEWS
Like we ended up having, I think, biscuits only at afternoon tea time instead of, you know, morning and afternoon tea (for patients). Staff had no biscuits whatsoever.

And in relation to their perceived lack of appreciation:

I think one of the things that nurses find most frustrating is that people take them for granted, especially a ward nurse, a hands on clinical nurse who's working with patients and working with people. Recognition of nurses, even just someone saying look, you know, you've done a really good job these last six months hanging in there and adapting to all this change and, you know, even verbal recognition is something that nurses would appreciate.

There's not many times that management or anyone comes up to you. It's really nurses patting nurses' backs saying look here's, you know, I think you did a really good job. That's quite hard to take.... I think that's what nurses feel, that we're always being asked to do more or cut back or do this or do that and if people would just say look, we really appreciate what you've done over the last six months that would probably mean a lot. So I think, it's not really much to ask I don't think. We're not asking for a pay rise.

These concerns are summarised in Figure 5.2. The diagram shows the focus of the concerns and the level of intensity of this concern.

The Senior Nurses' Concerns:

Staffing/resourcing and acknowledgement are two key areas that the senior nurses also speak about sharing the concerns of the staff nurses but from slightly different angles.

On staffing and resourcing:

I'm daily disappointed when I go round my wards and I see, because I'm with older people, just simple things like dignity and not being covered properly, shower doors not being shut, call bells not always within reach, the sip of water there in a cup ...... I don't see it. So yeah, no it's not there. And it's daily not. But it's the staffing. They're so focused on pills and dressings. Management have to get proper workload measures.

People are not able to get their heads above water.
FIGURE 5.2
THE CONCERNS EXPRESSED BY THE STAFF NURSES

The Intensity of Concern

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It would appear that the RHAs not giving the adequate funding and therefore the scheme is if we don't economise at the workplace then we'll lose the contract but the people at the workplace are saying we've never been funded enough, it's not actually our fault, so it seems to become a very much, "they" have to pull their socks up whereas anything good "we" have done well.

Acknowledgment of nurses by management:

*I guess I just feel devalued

They're not very good at saying to them "you're great, what you do is great", they don't say that. They don't seem to know how to say it.

So there's gaps in the system but there's no money to stop them. I didn't blame anybody, but it, but it's hard. We (nurses) take the load.

On leadership and management:

*There's leadership and there's management and then there's nursing. So I guess management is about managing resources, so that's people, money, budgets, putting in improvement programmes, those sorts of things. I've been interested because this is like the first experience I've had of being near managers so it's been quite eye opening for me in terms of seeing what they actually do. Then I have to look at individuals and how they do it. I think leadership is something quite different and leadership is about holding a vision and being able to get other people to see it and to get towards that vision, move towards that vision by putting in the processes or the structure to get there...... What's happened lately is they've retreated into "management without vision" and that's what's really affecting everybody.

Under the new CHE they started talking about quality and although the language was different - it was management language - it had parallels. Finally somebody was talking about the quality of care and you know they'd say "customer focus" and I could say "client centred" and there was something there that was the same. But now when they retreat back into budgets they lose, they've lost it. They've lost the vision and I guess people do that when they're in survival mode

*I truly believe that nurses should be in at the planning level. Because of all the issues we see by working with people and, to me, that's why it's exciting.

On the broader concept of healthcare which included the community:
It's about helping people to deal with what's going on in their life at the time around health and health can be as broad as you want it to be.

If we had nurses involved with the assessment clinics, the care in the wards, the follow-up at home, the case management role, you know I can really see that being a very cost effective service but at the moment we're sort of hanging it together between ourselves.

The way in which nursing care was measured or was valued:

'I think the performance measures that they wanted to develop were tools for central government and they weren't focused on any kind of client or quality indicators.

I find it a grave battle talking to the CEO. I see these customer surveys and they're about hotel facilities. I have to stick drips in people and naso-gastrics down people. I have to aspirate wounds. I have to tell them they've got terminal disease, yet how can you evaluate that. You know, yes they can go out and say look everybody was caring and supportive but if they were in a total rejection of the fact that they were given that diagnosis I mean they're going to hate everything about this place.

How do I measure spending my hour with my young boy who's terminally ill? How do I measure spending my hour with a patient whose family, who's lost their husband suddenly? You know, how do you quantify caring? (strong emphasis by participant)

The effects of the reforms on practice:

The services provided have been defined better, but I think there's been reduced sharing of information and resources throughout the country and the competitive approach has hampered information sharing and research and it's hampered transfer of patients and it's hampered clients' needs being met through transfers.

In exasperation at the manager's of contracting for defined procedures the CNS says:

55% of our workload is an acute workload so we have an environment of unpredictable costs.

I think the good things about the reforms for nurses are that there are lots of opportunities for people to adopt leadership positions, to assume a leadership role for quality and advocacy for people and so lots of doors of opportunities
opening for nurses that want to put clients at the centre again by getting into management jobs.
(This enthusiastic CNS left in disillusionment only Week Two into the group work.)

Each time a new management system comes in and they promise the world and it ends up you still, you've still got to cut your budget by 5% or 10% or we're going to get sold off to (the competitor CHE) So, I mean, staff are very cynical but with justification because it's all happened so many times before, you know.

Figure 5.3 provides a summary of the concerns of the senior nurses.

The Managers’ Concerns:

One of the somewhat surprising aspects of the interviews with managers was the high regard with which they all spoke about nurses and nursing. They of course saw areas for improvement but the regard was very strong.

High regard for nursing:

A nurse is a person that can almost be this chameleon, that can fulfill a role that will meet a need in their client, it could be physical, emotional, mental - whatever - and they are adaptable and sensitive enough to know what these needs are. Sometimes they are explicit and sometimes they're implicit. I think nurses are very, perhaps not psychic, but sensitive.

On managers’ perceptions of nurses’ frustration at their conditions of work, particularly related to constant change and lack of resources

If they're kept informed and they feel that they can deliver good care then they're quite happy, they'll keep on. If they feel like they're in the dark, they don't know what's going to happen tomorrow and there's not enough of them or there's not enough resources, there's not enough sheets and towels, or drugs, or whatever they need and they can't give the optimum care to their patients that's when they start getting stroppy and negative, and that's fair enough - I don't blame them.

On the surprise that nursing was not more proactive in moving their practice forward and a sense that nursing was a “key” to improved health service delivery:
FIGURE 5.3
THE CONCERNS EXPRESSED BY THE SENIOR NURSES

The Intensity of Concern

HEAVY  MEDIUM  LIGHT  EMPTY
I suspect that a lot of our nurses don't actually realise here how bad it is. I think a lot of them have a terrible sense of frustration that something is utterly wrong but "shit I'm just going to do my eight hour shift and I'm not going to think about it - it's just too bloody complicated". So it's almost worse that that - at least in the medical camp I think that intellectually there is a much higher understanding of the issues. Sadly for nurses at the moment I think that there is an emotional awareness and a kind of spiritual awareness that something terribly wrong is on but they can't get hold of it.

They don't know if they can trust management and management has done ..... enough for them to know that they shouldn't trust us, you can't blame them for that. They can't trust themselves because they've lost themselves. A lot of them now don't want to trust the union because they sense that somehow that process has got distorted and are they really with us or are they on their union agenda? They don't trust the health reforms because it's all these C.E.O. and general manager types and accountants and what are they going to add value - and what value has been added from these appointments - hasn't happened yet! So I mean they're in a terrible bloody quandary and yet probably 80 per cent of them don't actually see it - they feel it, but they can't see it, they can't actually grasp it yet. **So I mean what state of mind some of them must go home at the end of a shift in. God only knows.** *(Emphasis by participant)*

But that just reinforced for us, to me personally, what a silly, bloody sad state of affairs the whole thing had got itself into and yet these were people (the nurses) upon whom the future of this organisation was going to bloody well depend on because a) they're our largest workforce b) they're the people who, from the health professional point of view, have the most contact with our patients and that would not change in the future and here was a bunch of dispirited, demoralised, lost professionals upon whom the future of this organisation depended, I mean it was bizarre.

"Well Christ, you bloody managers are here one year and gone the next you know what happens if the whole health reform thing does another leap and we get a different C.E.O. and a different management team and all the rest of it what then?" And there's no absolute answer to that apart from I think saying "well that is a real issue and none of us know the answer to that but if you come all the way back to basics in terms of your reality as a nurse the sooner we start to address it the sooner we might get somewhere.

Speaking of the role of the CNS:

*So leaders, facilitators, catalysers, you know, key, key, key roles.*
On nurses and managers coming from different philosophical positions:

I'm told off frequently that actually you don't understand you don't actually care about the patients you actually only care about the money and I say that that's not actually correct. I would counter that by saying that the better we use the resources that we've got we can actually treat more people than just putting all our dollars into one patient. If we manage those dollars well we can actually treat three or four patients but I mean if we blow it all on one, if we don't do it more efficiently... and I guess that's hopefully one of the things that will drop out of the health reforms that by using the money more efficiently we can actually treat more people, with the same amount of dollars.

On the political nature of the healthcare environment:

The effect of the reform has been to shake the top end of the system. That probably needed it. It has swung the pendulum right out to the commercial end of it. There is now a realisation, in my sense of reading it, that is not quite as easy and that the pendulum will probably start to swing back again to try and arrive at some more balanced business/health/social responsibility mix in the middle. Now what the hell that means for all of us God only knows but I mean that's where the challenge now sits. That will translate into building up a fundamentally new alliance between health managers and health professionals in which - there is always going to be a tension there - but to make that a creative tension and a more open understanding of what those competing ethics actually mean and to be able to live and grow positively with an open acknowledgement of what our intentions are all about.

It (changes to the health system) was clearly coming in and I think it came in with a poor understanding - well, professionals had lost their way which didn't help and I think there was a poor understanding from the Treasury Troughton view of the world of what that whole health professional thing was about. Given those two together it was bound to cause mayhem. And some of the professionals, I think the doctors, had been quite good at keeping a distance from the mayhem but politically had been quite astute at also stirring the mayhem up when it had become to their advantage to do so. I think for nurses it has been more tragic because I think they were fundamentally more utterly lost pre coming into the '91 reforms and post '91 reforms that they themselves and the systems have very much kind of spun them almost out of court, in a sense. And compared to the medical camp they have been major, major losers - not just because of the '91 reforms, that started a long, long way back.

These vignettes bring alive the levels of frustration felt by all sub-groups as they approach the opportunity for sharing of perspectives in the group work over the ensuing three month period of
working together. There are clearly differences of foci, and levels of miscommunication: for example staff nurses feeling very unappreciated when managers clearly do appreciate their work but do not communicate this to them. A lack of common understanding of decision-making priorities and processes, and the effect of decisions on the day-to-day life of the nurse or the experience for the patient, are also apparent. Figure 5.4 summarises managers’ concerns.

It is with this wealth of material for conversation that the group prepares to enter the group phase of the action research. In preparation for the first meeting each participant was given a transcript of their interview to review as a means of foregrounding their ideas for discussion.

**Setting Up and Keeping a Safe Space:**

When, finally, we met as a group in our small cosy annex participants were greeted and introduced informally and invited to have tea or coffee. The session formally began with a brief “centring” exercise to attempt to help people leave behind the distractions of the world from which they had just come, whether family or a busy ward, and to clear their thoughts and begin to focus on the group and its intention. This way of beginning a session was common to the practice of any teaching session in the department mentioned above.

As part of the establishment of ground rules for group interactions I used a modified version of the feminist group processes of Wheeler & Chinn (1991) which we used for teaching at the university. There were three key aspects of this process on which I focused. “Check-in” (renamed “checking-in” for our purposes), “rotating chair” and what Wheeler and Chinn called “closing” but which I renamed for intuitive sense in the context, “checking out”.

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FIGURE 5.4
THE CONCERNS EXPRESSED BY THE MANAGERS

The Intensity of Concern

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Check-in is a time for each individual to focus her (sic) awareness on the purposes of the gathering, to share with the group any circumstance that might influence her participation in the process, and bring her individual perspective for this gathering before the group (Wheeler & Chinn, 1991, 29-30).

We also referred to this process colloquially as “doing a round” as participants were seated in a circle and people spoke in the order in which they were seated for the purposes of the checking-in.

The process of “rotating chair” was used to minimise the possibility of any one or two people dominating conversation or becoming engaged in a dialogue to the exclusion of other group members, echoing Wheeler and Chinn’s intention: “The primary purpose of ‘rotating chair’ is to promote every woman’s (sic) viewpoint being heard, with each woman’s input being valued and necessary” (Wheeler & Chinn, 1991, 30).

Once discussion begins, a group member expresses her desire to speak by raising her hand. The woman who is speaking is responsible for passing the chair to the next individual who raises her hand. The chair is passed by calling the name of the group member you are recognizing to speak next (Wheeler & Chinn, 1991, 38).

The group quickly realised that signals could be subtle as long as the speaker was paying attention to all group members. The consequence of this was a high level of engagement and involvement for everyone.

Checking out is an essential part of the process.

Each woman shares her appreciation for something that has happened during the process of the gathering, her criticism leading to growth and change, and an affirmation that expresses her own personal commitment for moving into the future (Wheeler & Chinn, 1991, 30).
Whilst nervous about introducing a process which was foreign to a “Kiwi” way of interacting, I was surprised by how readily the group took on the process and were self-monitoring if any aspect looked like being neglected. The only aspect that was not fully embraced was the third component of the closing which was the affirmation. It was seen as just too “out-there American feminist”, as one participant put it, but the appreciation was adopted as a treasured part of the ending of the sessions and the criticisms were astoundingly constructive and were indeed imbued with considerable, respectful frankness.

The checking-in and checking-out process enabled everybody to have dedicated speaking space at two points in each session. It ensured also that staff nurses and managers heard each others’ perspectives and this was then often food for thought, reflection and discussion at the next session. I considered this idea of a dedicated speaking space to be particularly important for the staff nurses, as I was aware of their potential triple silencing as women, as nurses and, within the group, potentially constructed as occupying the “lowest” position on the employment hierarchy (Belenky, Clinchy, Goldberger and Tarule, 1986).

In the first session with the first “round” or “checking-in” people introduced themselves and spoke briefly about why they had joined the group and what they were hoping to get from it. Having already explained the research at the time of consent and again at individual interviews, the purpose and process of the research were reinforced before we began the conversation proper.

This is a different sort of research, by name action research, where we work in a group and the interests of the group allow the common themes to dictate the direction we take. There isn’t necessarily a final endpoint but the purpose of it is to try and shed light on something that is not necessarily well understood. We have a messy muddle, the health reform is a messy muddle and one of the forms of research that works with messy muddles is this sort, so that people can come from different perspectives, a bit like a CAT scan, that in the health reforms all of the different ways in which we look to try and get more of a sense of the
three dimensionality of it. No one has the answer, because there isn't an answer. There are multiple answers, and the more we can get that three-dimensional picture, the greater the understanding and the greater the illumination, the light shed in on what it is we are looking at. Once we know it and understand it and walk around it, appreciate the different sides and the different understandings, we might be able to work and practise in a way which is more productive (Jill-GroupI).

One of the things that is important to action research particularly in the sort of action research that I choose to be involved in, ...is that it is informed by a feminist perspective that this is to say we create and keep a positive speaking space. What that means in turn is that we don't come here to carve each other up. That we don't sit here frightened to speak because someone will take from the room something that was said...We all need, as a group, to make a commitment to holding this as a positive speaking space, so that we can throw any ideas out without fear of having repercussions from those ideas outside this room. I think we need to make some agreement to that because it is only in that position of trust, that you can speak frankly about the sorts of things that are causing the disconnections between management and nursing and to try and understand those points of connection or disconnection. It is only by putting out the very real and painful examples sometimes of those things that allows us to look at them and see how we can improve....So I think we have some sense of the "OK'ness" of that and, what is said in this group needs to remain confidential in terms of the stories that are brought forward and the discussions that we have (Jill-GroupI).

I clarified my role in the group as participant, researcher, facilitator, gopher:

I see my role in this group as in some ways helping to facilitate the discussion but also being a gopher, go for the food and for the tea and coffee and I will make sure the tapes are recording correctly. I also undertake to chase things that the group might want to have more information about. That doesn't mean I am the only gopher we can have in the group. If it's something that you want please feel free to bring it along or if you have found articles of interest send it to me and I can photocopy it for you and circulate it, so that we are all in our own way repositories of information that we can share with the group. Action research process is about spirals of understanding, about throwing something in to try and get a better understanding of something so that you can then research further, can reflect on what we have found, we can increase your understanding and move collectively to a different position and go about these spirals of increased understanding (Jill-GroupI).

And finally I spoke in accessible language of the importance of reflexivity and dialectical processes.
Initially my plan had been to transcribe the group tapes and return the transcripts to each participant between group meetings. At the first group meeting participants requested that this be modified as they felt they would have no time to read two hours of typed conversation between sessions. They requested that as the participant/researcher I listen to the tapes, summarise the conversation and distribute this as a one or two page summary which would then form the beginning conversation of the next session. Nervous of what this did to the idea of collaborative reflection I was soon reassured when the first summary provoked robust discussion relating to what had been remembered as discussed and what other people had seen as key points but which I had not privileged to the same extent. I believe, whilst my written summary was a conversation starter, it was by no means privileged as the authoritative account. This was a great relief and reassured me that critical reflective processes were clearly in evidence for participants between meetings.

Each session began with the centring exercise followed by the checking in round and it was at this time that participants put forward their thinking from the last session or the issues they wanted to discuss that evening. Those on which we focused were those where there was clear divergence of opinion, as is appropriate with action research.

As indicated in many descriptions of the action research process, it was suggested that participants keep a research diary. I was the only one to do so formally but most brought the summary sheet from the previous session with them on which they had scribbled prolifically; I decided this was the busy clinicians’ version of a research diary. The issues which were raised are detailed in the following chapter. They ranged from lack of vision and leadership, to
resourcing for change, responsible subversion, contradictory expectations and different ideas on what constituted economic responsibility, to name but a few of the rich tussles.

**Concluding the Research Phase without Finishing the Conversation or Disrupting New Relationships:**

The last evening brought some of the fiercest intellectual battling. The staff nurses had become progressively more articulate and were more verbally assertive than in earlier circles. When it came time for the final round everyone expressed regret at the research ending. The group suggested they would like to keep the group meetings going and, as the group left, a date and time had been set for the first meeting that would not have been part of the research. It was indeed heart-warming to see and to appreciate the value the participants had ascribed to their time together. Evidence of this appears at the conclusion of the group process discussion at the end of Chapter Six.

As is consistent with the “Peace and Power” feminist group process the final session together, whilst determinedly continuing the discussion, was also a celebration, a celebration of what we had all gained from the sharing of thoughts and ideas and concerns with each other. We had discussed the messiness of the “ending” and had no expectation of what McNiff would later describe as the need to “beware of happy endings” (McNiff & Whitehead, 2002, 90).

Action researchers do not aim for closure in which notionally unsatisfactory situations transform into satisfactory ones. They start from where they are, albeit with a sense that something needs doing, even if that something is carefully thinking about where they are. They take action to evaluate whether what they are doing is the best it can be, and how they can improve it where necessary. This often leads to some improvement but not perfection.... Learning from the process when things do not go right is as valuable as when they do. The struggle to make sense is the research process (McNiff & Whitehead, 2002, 90).
CHAPTER SIX

The Group Work

A heart-to-heart about the life in “messy swamp”

In the varied topography of professional practice, there is a high, hard ground overlooking a swamp. On the high ground, manageable problems lend themselves to solutions through the application of research-based theory and technique. In the swampy lowland, messy, confusing problems defy technical solution. (Schon, 1987, 3)
"The heart in Voh, New Caledonia"
In *Earth from the Air*
Reproduced with permission of Thames Hudson.
CHAPTER SIX

The action research process was undertaken to try to access practice understandings of nursing by nurses and managers within the context of Research hospital (RH) in a metropolitan Crown Health Enterprise in New Zealand in 1995. The action research process itself, the detail of the setting, the people and the process itself were detailed in Chapter Five, as was the outcome of the preliminary individual interviews with participants. These interviews revealed that each sub-group of staff nurses, senior nurses and managers had significant concerns related to each other but the perspectives were varied. This heralded a rich mix of ideas for conversation.

This chapter engages the reader with the group as it works its way through meetings held every two weeks for a three-month period, seven meetings in all.

Obviously it would not be appropriate to provide a verbatim recording of everything that was said in all seven sessions. I have, as participant/researcher, had to choose the passages I felt best represented the issues and conversations that took place. As indicated in the previous chapter I was requested by the group to provide a summary of the key conversations of each session at the beginning of each subsequent session.

In constructing these summaries I used a method of highlighting those areas that were contentious, where there were contradictions. This, post-hoc, I found to be known as dilemma analysis (Winter & Munn-Giddings, 2001). Winter and Munn-Giddings contend that dilemma analysis enables groups to identify issues that are ripe for taking discussion further and disrupting taken-for-granted understandings, an important aim in action research.
The summary analysis was then fed back into the group as soon as people entered the room for each session. This was supplemented by any additional analysis coming from group members during the checking-in period of either the summary I had made or thoughts they had had between sessions. (See Appendix 1 for examples of the summaries.)

The conversations have been captured in their essence through snapshots of verbatim conversation. Key concepts within the conversation are highlighted and at times segments of conversations are used to illustrate the interplay between participants. As indicated in the previous chapter the participants are not identified by name but rather by positional category as anonymity was seen to be paramount over direct attribution.

The preliminary interviews had provided a loose framework of concerns and had certainly foreshadowed a growing tension between the CNS group and management about the degree to which they were being supported in fulfilling the role to which they were appointed. In the first group the senior nurses are quite vocal, as are the managers. The staff nurses are quiet but do participate fully in the checking-in and checking-out and at other times are quite saucer-eyed at the conversations between senior nurses and managers.

**Group Meeting One: “The talk and the reality are not quite meeting” (Senior nurse).**

There is little hesitation in engaging in open discussion right from the first checking-in process for the senior nurses and managers. Issues put out for discussion in the first ‘round’ include the difficulties with the “restructuring” within the hospital, nursing having been perceived by managers to have “lost its way”, lack of vision both for nursing and for the R.H., and the exhaustion of incessant change. These issues play out through conversation exposing dissonance in opinion. There is a tacit acknowledgement that this first week is primarily about putting things
"on the table" rather than dealing with them in depth but there is also a clear willingness for the hard conversations to happen.

Quickly following the round the group enters a discussion of the local restructure, the ideal versus the reality as experienced. When the CNS group were appointed there had been a stated commitment to quality, best practice and collaboration. On the ground in the day-to-day it is experienced differently:

Senior nurse  I don't see an honest strategic solution necessary to move nursing ahead...We require this huge amount of time out of the area for the planning and the quality days. There are all these days which relate to the change to the structure of the organization, but at the same time we are really hamstrung because we don't have the money to either replace those nurses so they can attend the study days without leaving an area severely short-staffed. So that's my dilemma. I feel that if the organisation had an honest strategic commitment to this change that all these things should be made easy... I thought there would be a much more common philosophy and a collaborative one and I am just wondering at the moment whether it really is there - a collaborative vision.

These perceptions are elaborated on by another senior nurse:

There was meant to be a shared governance philosophy here and we would be sharing participation in any changes. I thought that the vision had been a bit more articulated, the quality vision and the business vision lined up along side each other and this would then be a joint vision, lined up with quality patient outcomes. And that an ethic of care had been incorporated into the quality vision. I am now worried about the commitment to it. The talk and the reality are not quite meeting. (Emphasis added).

And immediately by the third senior nurse:

The way I see it there is a commitment on paper to a certain kind of restructuring but on a day-to-day basis we're actually prevented by our lack of resources to do many of the things which would make my job really useful and valuable to the organisation.
The first senior nurse again speaks, reinforcing the point that whilst they have a critique of the current situation, they very much want to be involved:

_I know there are more changes afoot I really want to be part of that, I know the CNSs want to be part of it. They want to be consulted and want to participate very much in the changes as they happen and I'm still very excited about the potential but still a little bit disturbed about it at the moment._

In attempting to address the issue of “honest strategic commitment” raised earlier one of the managers broadens the conversation sharing the demands under which, he, as a manager, operates:

_There are some real horrible things coming through with these reforms. How it comes down from the mountain from the lord and masters on high (RHAs and the government) and one of the real frustrations is that every time something new comes through it comes through with a slightly different spin on it so you think you have got some direction, some commonality and you find next week something else will happen that distorts it again. It becomes a real dilemma in terms of how you communicate that to others, and if you communicate it honestly, and one week you say one thing, the next week you say something else, the week after that you say something different again. All of what you have said has been the reality and that is the honesty of the situation, yet it is very easy to perceive that “shit you’re the manager and you don’t know what the hell is going on.” Another big paradox as I see it all the changes have come through have sort of thrown around the big boxes of management and organisation and RHAs and Area Health Boards and all that stuff but if you think about what has actually changed in terms of how, say a nurse practices her craft at the bedside I suspect not a whole heap would change over many, many years. (Emphasis added)._

_Senior nurse_ I wouldn’t agree with that completely. I know a lot of time is spent accommodating all those managerial changes, but even though your actual nursing and how you operate and how you are working and giving care doesn’t change it is still in a working environment in an organisation and you are constantly accommodating other changes peripheral to your work.

This is a particularly interesting exchange as the manager expresses vulnerability in his position. He indicates that he wants to communicate honestly but also not to pass on the confusion of his position to the staff, understanding their need for consistency of management message. Having exposed this, he goes on to suggest that whilst things have changed enormously with the
“throwing around of the big boxes of management and organisation”, not much has changed at the level of patient care. This latter point is immediately picked up by the nurses, leaving hanging the broader point about constant change at the management level or management vulnerability.

The manager attempts to clarify his meaning and the following exchange takes place:

_The real change of the health reforms is yet to happen and it’s about challenging some of the clinical assumptions of how we work. That has all kinds of threats and opportunities in terms of the clinical people involved in this. I mean how a clinician practices their craft in a very fundamental way._

Senior nurse  So you’re not just talking about service delivery structures?

Manager  I mean, what is the role of a clinical nurse from year 2000 in terms of managing a member of our community with a particular illness, as part of some clinical health professional group? Now for me I don’t know the answer to that but my gut is telling me it is quite a different how it has been for the last 10 years. It is a real opportunity. There is a huge vacuum that has to be filled very quickly if nursing is going to take the high ground that’s sitting there. Because I don’t think anyone else has got an answer. I think one of the real interesting things is that management have a huge problem with this, absolutely huge problem.

Staff nurse  I think from a staff nurse’s point of view there has been a lot of change at the hospital over the last 18 months and some of us are quite sick of change, with you’ve gotta change this and you’ve gotta do this and this is what is happening next month and people are just saying just give us some time. We have to get used to one thing before you bring in something else.

The conversation is being played out at three levels – management speaking abstractly about opportunities for change, the need for haste and the external pressures. Staff nurses are embedded in the reality of practice with limited resources and change fatigue. The senior nurses are taking a middle ground – keen for involvement but cautious about the resources needed to move forward, seeking involvement in shaping change and developing strategies that will move positive change to the level of everyday practice.
Not surprisingly the issue of leadership arises and again differences in standpoint emerge.

Consultants had been brought into R.H. to assist with the change process; however, there had been somewhat of a clash of styles:

Senior nurse  *MXX management* (a named consulting company) talks about leading from behind and when he talks about leading from behind the way I see that is that it is like a bulldozer.

The manager’s sense of leadership is expressed in the following passage:

> We said to ourselves as management that we would expect the first nine months that probably most people spiral downwards because you made a massive shift, you’ve got new people coming in new way of working and all the literature tells you that and then things pick up in the next three months and then the second year it really starts to hum... We made a commitment and it was a huge commitment ok, a bit wobbly, but you have to actually allow it, rightly or wrongly, to actually be in a degree of chaos to try and support the chaos and out of that chaos some new direction will start to emerge and for management it is very difficult to do because if this thing goes wrong the General Manager, loses his job, all the EMT will lose their jobs they all may not survive. (Emphasis added).

No one picks up on this disclosure of vulnerability of the senior management team but rather a senior nurse takes up the issue of chaos as a necessary part of change management:

Senior nurse  *It’s interesting that you mention chaos because from where I sit that what it was like. You don’t have to have chaos to get progress and innovation and creativity. There are ways of doing it that still harness the staff participation without just leaving them to it with no direction, no leadership, and no help and hoping like hell that they will make it work from underneath. We can do a bit of that but we are still hoping that there will be some nurturing. There is so much chaos. Transformational leadership and giving vision can still develop a culture where people have ways of participating in some definable processes to prevent so much chaos. There has got to be a blend.*

In this and the following conversation it becomes clear that the senior nurse group and some of the staff nurses are well aware of the literature on leadership. There is a clear philosophical commitment to shared, participatory leadership which takes into account the degree of change to which people will willingly commit.
Senior nurse  *(It’s important) not try to change too much in the short term. It is very much a slow process of trial of change. Sudden change, frightening change or changes that occur overnight, to me, are only detrimental in the long term.*

Manager  *Ok but I mean, the reality is that more change is going to happen whether you like it or not. There will be more uncertainty and less certainty and that is a given for the next ten years. The goal posts are going to keep changing, so where do we get some solid ground that: a) we can keep ourselves sane, and I’m saying we in a nursing professional sense, b) add value to the changes as they come through and, c) lead from behind or in front and make those changes do what you actually want them to do*

Senior nurse  *But we need to be more involved. We have to look at the day-to-day stuff at the same time that we look further ahead. The strategic planning and that is all fine but take into account the day to day stuff at the same time. The nurse-patient relationship and care that is needed everyday.*

The first group session focuses on the restructuring taking place locally. The nurses are putting onto the table their concerns over involvement in shaping the change and expressing their disquiet at the effect of the changes to date at the level of everyday practice. Management tries to locate their difficulties in the broader context but this is rarely picked up in this session. However, the language used by some members of management is very interesting, referring to their managers (the government and the RHA as “Lord and master on high”). This is repeated in later sessions without any apparent sense of the dissonance between the way they speak of their ‘management’ and they way they seek to be thought about by those they manage. They illustrate a “chasm” between themselves and the government and RHA that they see paradoxically as unnecessary and unfortunate between themselves and the clinicians they in turn manage. See summary in Figure 6.1.

**Group Meeting Two: “It’s responsible subversion I’m talking about” (Senior nurse)**

At the beginning of the second session it is immediately obvious that thought had been given to the outcomes of Group One. (From hereon the groups meetings are referred to simply as Group One, Two etc.)
FIGURE 6.1 GROUP MEETING 1 SUMMARY

"The talk and the reality are not quite meeting"
Manager: *Well I guess there are a number of things sort of floating around in my head after last group session.*

Issues such as trust, honesty and communication are immediately introduced, as is the idea of “them and us”. It is seen as a quite mobile concept with who is “them” and who is “us” able to change at any point in time.

Senior nurse: *Talking to the people about what is happening and how can we do things better, all I get is “but they, but they, but they” and you try to turn that around and to impart the philosophy that it can’t be “they” any more its got to be “us”.*

The conversation then broadens and deepens the issues raised in the previous session. The day-to-day realities of the patient cared for in the public system are explored and juxtaposed against the expectations of an environment of competition and contracting for services.

Manager: *Over the last two or three years most commercial managers go into a new organisation, they sort of shift around the big boxes of the organisation to increase the profits. I think there’s a growing sense that unless you can actually get down to the microcosm of how people practice their health craft, both clinically and from a resource point of view, you’re never actually going to make any progress....Some CHEs still have very much the old commercial model of shifting boxes and beat up the people, whereas others have reached the same stage of thinking that we have. That you actually have to start looking fundamentally from a different place. That may sound crazy to health people but all the managers are from places in other industries and I think that they’ve just tumbled to the fact that health is different and that they need some new sort of thinking.*

Leadership is again brought into the conversation by the senior nurses with a reinforcement of the issue of the need for clinician involvement raised in the first group meeting. What emerges is a dissonance in that management believe they have taken a “hands-off” approach in order to allow the senior nurse group to lead practice change but the senior nurse group have not seen this as the most appropriate or helpful strategy:
Senior nurse  Strong messages of hands-off from management. You have to be the leaders, there's not going to be a nurse advisor. It's up to the CNS group. But it's almost as if that's too hands-off. There's no support.

The space is now open for a discussion about the reality of the restructure and the perception that what one calls "freedom" another calls "lack of support":

Senior nurse  People simply cannot do that (the leadership required for the service change) in addition to their work (patient care).
Senior nurse  I had that problem today I'm supposed to be in three different places in the period of a day. Every day you are juggling the priorities. In the end the clinical side of it is always the most important- it's very hard to satisfy every area of demand.

The following interchange tries to take this issue into the broader business arena:

Senior nurse  What would a business do about this? Would a business expect their most expert people who were employed to do a particular job to be also designing a new system and also trying to get all of the audit data - I couldn't imagine that they possibly would - so what would they do?
Senior nurse  Employ someone to help them. Support people. Get other people in so that they can share the load.
Staff nurse  Is it part of the nursing or health professional culture of making do, that we do this?
Senior nurse  "Coping ill-advised."...
Manager  I don't know that it's all that far away from - what would you call it "responsible subversion" because it continually camouflages...

Here the manager refers back to a concept introduced earlier in the session where nurses break rules when they believe their actions to be in the best interests of the patient at the time. This concept, "responsible subversion", comes from an article by Sally Hutchinson (1990) "Responsible subversion: a study of rule-banding among nurses" and it becomes one of the key concepts for discussion in the remaining sessions of the research as it encapsulates what the nurses perceive as a fundamental ethical divide between nurses and management. Because of its pivotal nature this ethical divide will be discussed more fully in Chapter Seven. In this session, however, the very mention of it diverted the conversation away from leadership support and into the depths of clinical examples of "responsible subversion".
Senior nurse: I've got a young guy and he's 24. He can't swallow, he's got gastric Ca, and we need a CT Scan. If he wasn't an inpatient he would have to wait three months for a CT Scan, inpatients get priority over outpatients. There's all those politics that go on with fighting for resources. We've cooked the book so many times... You have your elderly person admitted because if we wait three months for that man to get a CT Scan, he's dead - okay? So we admit him in the books, he comes in, touches base, signs his form, goes home, CT Scan ring us, we ring him, get him in, get the Scan... he doesn't even hit the ward.

Senior nurse: Sometimes I have 35 patients in a 31 bed ward because you've got a lot of people sitting waiting for a CT Scan, that you pretend he's in the ward, ring home, get them to come in... the whole thing is done. But the patient who had the Ca gets his operation... it's responsible subversion I'm talking about.

Researcher: But by manipulating the system in that way we are band-aiding are we not?

Senior nurse: But you don't care about that at the time.

Later in the conversation one of the staff nurses reflects on the notion of responsible subversion:

Staff nurse: I think your comment about responsible subversion is beautiful.

Manager: But it spins into a heap of other things. Because if a commercial type manager operated that way, they would be fired instantly because that process would be audited and you'd be gone like that. What you're actually saying is that the system's flawed, we have to actually have to subvert it, put on a band-aid, to achieve something we want to achieve. A manager looks at that and thinks "My God, what the heck's going on here?" The manager challenges that and gets told by the clinician that they don't understand the clinician's clinical issues, bog off out of here. And we're back across the chasm again. Both parties knowing that something's really pretty sick here, but neither party actually having any conviction to deal to it. (Emphasis added)

Manager: The problem is that it develops a level of mistrust across that clinician/management chasm. Managers know that this stuff goes on all the time...

Senior nurse: There are all sorts of things that I agonise over like you know when Mrs. XX who's on the sickness benefit comes to have her pilonidal sinus dressed she can't afford to go to the chemist to buy the dressing so you give her a few pads because otherwise she's going to get the wound infected - you've seen it all before and all those little things that as nurses you do, even though you know you don't want to do it, some of us are stronger than others

Manager: But the more we camouflage that...

Senior nurse: It's the ethical dilemma that you have as a health professional.

This provides a flavour of the in-depth conversation about the moral dilemma for the nurse in rule breaking or bending and the very different perspective held of this behaviour by
management. Both managers and nurses are outraged by the response of the other and this proves to be one of the key dilemma points of the research.

There are two further significant conversations in Group Two. One relates to the lack of clarity of expectations by the community of service provision. The second conversation relates to the myth of competition.

Manager I think we need to be clear in the business we are in and as that becomes clearer and as we have specific costs we can then transfer that information to the RHA. They have the responsibility of providing the service to the community. We can be advocates for our community. I think there is a big grey area because the average person in this community believes that CHE has the responsibility for all their medical services so you could say that the RHA have done a wonderful marketing job and we perhaps haven’t.

Staff nurse The people of this valley do still think that you are theirs, but you are not allowed to act in their best interests, what do you do about that?

Senior nurse I know. They are the taxpayers, they are purchasing the services but they don’t have any control over the services that are being purchased. It’s the RHA that controls that. I don’t think there is any trust anywhere in the system.

A powerful example is then given of a woman who would previously have been transferred to the neighbouring hospital in an ambulance with a nurse escort for a test, but who under the new system was seen as not sick enough to require an ambulance. She was to travel in a taxi without a nurse escort. The patient then sat for several hours in a corridor, vomiting, with only her son with her. This incident is of enormous concern to the nurses but the managers see it as unfortunate but not a reason to change a policy about un-escorted travel.

It is in response to this story that a staff nurse introduced another term that becomes important to the group. She suggested that nurses “buffer” the patients from the extremes of the reforms. Nurses worry about the minutiae that are not seen by the managers as company business but are seen by the nurses as important to the patient.
Staff nurse  Nurses expend emotional energy worrying about these things, exactly these minutiae. But to the patient they are not minutiae and helping handle these things is not minutiae.

Community expectations and the nurses’ role in “buffering” patients are returned to many times in subsequent sessions.

The competitive environment then becomes the focus of conversation. Many stories are told which include the imperative of competition in the government requirements; however, these are contrasted with the reality of the situation where competition is either not structurally possible or is undermined for the sake of the patient. Here, the dynamic is slightly different and there is no difference in the positioning of managers and nurses. No one sees “competition” as really playing a role in the reform process in any way but rhetoric.

Senior nurse  The system is not built for us to have a good network and good relationships. I need a special catheter for a lady last week and I’d rung all the firms and so I rang (the “competitor” CHE) I rang the renal unit and the staff nurse just about tipped the department inside out then rang me back three times trying to find it. She then referred me onto another department who did the same and this wonderful collegial relationship was there. I was actually fearsome I wouldn’t find it. Thank God it hasn’t gone out the window but then you hear the other side of it of they charge for this and charge for that or something and you know you get that commercialism hitting you in the face. I was thinking, as nurses we have to retain that collaborative approach and care about the patients before the money.

Manager  So what is it you’re saying about nursing

Senior nurse  I hope that they (nurses) have the value of caring and that knowing my dilemma for this particular patient. They knew the problem I had and that would be the whole focus, to help me solve that patient’s problem.

Manager  Well I don’t know, maybe this competitive element amongst the CHEs is actually a myth.

This reference to nurses caring raises the issue of “who cares” for the managers and one is drawn to say:
There seems to be a perception at times that management don’t actually care about the patient and I can assure you one hundred percent that the reason the managers are working in the place is that we have a concern for the patient as well.

Manager     A lot of managers are extremely interested in a patient's outcome as much anything else, as much as their interest in the financial outcome.

We see here for the first time a real playing out of the tensions created when practice engages people who operate from different philosophical positions. Here the tensions show in relation to different ethical positionings of good for the individual versus good for the greater number. A summary of Group Two appears in Figure 6.2.

Group Meeting Three:  “At what point does responsible subversion become irresponsible subversion?  (Manager)

Responsible subversion is immediately the subject of conversation in Group Three, when in the checking-in a staff nurse recounts a telephone conversation about the topic with a friend:

Staff nurse  What has come out for me in the last fortnight came about from a conversation that I was having on the phone. I was talking to Mary and she was asking how the research was going we started talking about this responsible subversion. She said “it doesn’t work with managers, it used to work in the old doctor/nurse game because it was inherently part of the old doctors and nurses way to work.” It’s something I am going to think more about. There was something in the relationship between doctor and nurses that fostered the development of responsible solutions and that was an absolute ground rule that just wouldn’t be there with non-health professional managers.

This is quickly challenged by a manager who asks a fundamental question:

It’s done without thinking. Patients in wards that really don’t need to be there, extra days because someone can’t pick them up. At what point does responsible subversion become irresponsible subversion? (Emphasis added.)
"It's responsible subversion I'm talking about"
This question provokes a discussion of the ethical frameworks that underpin the practice of nurses and managers. A manager who has been a nurse captures the essence in saying:

"There is a terrible junction when you are involved in management and caring where you have to leave one and pursue another. It gives it a very blurred middle area, at some point you have to fall in one camp or the other. Where you are deciding what you are going to do and how you are going to respond to it.

Senior nurse: I wonder if it is the ethical framework perhaps that the health professional works more closely with, yet managers must fit into a framework as well. At the moment it is perhaps the greater good for the greater number, doing the right thing but as we know in the real world there is a great conflict when you look at the individual and the good for the community.

Manager: I wonder if when you are a manager because you are further away, sometimes it's easier to objectify things. But (in the clinical area) it's always personal, it's always immediate, it's always happening but for managers it's still real but it's at a distance.

Again stories are shared and the nurses are in agreement that it is “just not compassionate” to send patients home when there is no support available for them. The manager’s response whilst flippant does illustrate the differing perspectives:

"He could have stayed at the Park Royal (an expensive hotel) and still have cash left over. No I’m serious, in terms of cost.

Whilst acknowledging the cost of the continued hospitalisation it is equally clear that money is not moveable and that this exemplifies the false economy of many of the reforms. Much of the “responsible subversion” of the nurses is related to the lack of coordination between what is required for the hospital and the lack of associated community services to make this possible. The nurses have a broader picture of the patient experience as encompassing what happens to him or her at home rather than a hospital-centric vision.

One manager’s perspective of nurses acting “compassionately” by prolonging in-patient stays uncovers part of the management/clinician “chasm”:
Run that through the loop of the standard health manager's thinking and that information gets translated in a whole different sense, to do with nurses manipulating the system, not managing the care properly, wasting our resources. Therefore, nurses by definition are inherently bad, lazy, useless or whatever. All that stuff comes back into it, therefore they (nurses) need to be told how to practise, know what I mean?

Senior nurse  Therefore it doesn't matter whether you have highly qualified nursing staff or people not qualified.
Manager      Well it does matter because unqualified people would follow your rules.

This apparent devaluing of clinical judgement of the experienced nurse draws audible gasps and change in body language which suggests the managers and nurses have retreated to either side of the metaphorical chasm again.

The attempts to get back into meaningful communications at this point are interesting. There is a real will for rapprochement. In an attempt to find common ground a manager raises the issue of best practice as something everyone can be committed to:

I think that best practice is really the common focus that can be shared by everybody.

Staff nurse  Best practice for individuals or best practice for the majority, or best practice for the community in which we live?

This is illustrative of the movement between the simple and the complex. It appears to be quite characteristic of the conversations that as soon as a manager makes a general or abstract statement the nurses immediately move to the complexity and muddiness of the realities of the practice context. The nurses display a very strong understanding of the international literature on management in healthcare. Their ability to implement this knowledge relates to a lack of support, time, communication structures and financial resources for staff development and appropriate staffing levels.
This knowledge of the contemporary literature is displayed in each session; for example, in Group One there is a discussion about the need for post-acute care services in the community particularly with respect to home-based IV therapy; in the discussion of best practice in Group Two, the nurses discussed clinical/critical pathways and nurse case management. The lessons from the research on those hospitals that recruit and retain their nurses most effectively, known as the Magnet hospitals, are introduced in Group Three.

Senior nurse Looking at the magnet hospitals in America’s interesting that they are quality driven from the nursing perspective in that the largest part of your workforce is nursing and they demand quality from every other practitioner. They monitor quality, taking that customer focus right in our hands and demanding that quality to the client…. But they have a very strong nursing leadership which is what we as CNSs would like to have to be our advocate at that decision making level. Well that’s my dream that we can do it whether we have a leader or not.

In Group Three the conversation of best practice prompted a discussion of discharge planning. The issue was introduced by managers as a mechanism for preventing the bed block that had been the subject of the responsible subversion conversation. The nurses were eloquent about the reality of introducing discharge planning given their patient population and staffing issues.

Staff nurse But often you are barely keeping up with your workload right now without having to do discharge planning when the person has just been on the ward five minutes, that is just inappropriate as far as I’m concerned.

Researcher Talk more about that, why is it inappropriate?

Staff nurse Because it’s not the here and now. It’s the person who is an acute admission who can’t even breathe. The first day to me is keeping that patient alive and safe and doing safe nursing practice, not discharging people. Besides half of the time you haven’t got the time to do it and that’s why it is left.

Staff nurse Often you don’t even know if a patient is going to survive, and then all of a sudden the next day they are breathing and likely to be home tomorrow, and you are actually pushing them out so fast you’ve hardly got time to think. You don’t even get time to get to know them.

Senior nurse There is no way that any one of us can have five minutes to think about discharge problems. I felt the frustration by the end of the duty that this has been dictated to by admitting all these patients that the nurses have to look after and do the best for, probably not the best quality care you want to give but you just have to try to get them into bed and comfortable and safe. It’s the most
unsatisfying type of nursing but you are compelled to do it. Probably 50% of your working day or more is to do with staffing levels. (Emphasis added).

Researcher But staffing for what, what are you staffing for when you say staffing levels. Staffing for safety or are you staffing for patient care for best practices.

Staff nurse For safety.

Senior nurse Doesn’t that make talk about best practice a lot of mumbo jumbo?

The resourcing for staffing initiates a classic example of cross-cultural interaction. Nurses are speaking of the “agonising” over calling in casuals to help with staffing levels when they are overloaded. The managers’ response is “why should we believe you when you have just been telling us how you constantly manipulate the system.” This is again a comment that sends people scurrying back across their respective sides of the chasm. The nurses see this as a deeply offensive comment. They see an enormous difference between manipulation of a system for the sake of a patient and manipulation for their own sake.

Not surprisingly the conversation moves to stories of nurses coping under difficult circumstances – nurses as martyrs.

Senior nurse You say it jokingly but quite seriously I wonder how much of it does come into a sense of the righteousness of behaving this way.

Senior nurse We can look at the patterns, the way we work and alter things. I think this is what the health reforms are trying to do, to make us open our eyes a little bit and think a bit more, and question why, why, why are we doing it this way?

Not surprisingly the conversation reverts to resources:

Staff nurse We are burning the candle at both ends all the time.

Manager Two thoughts were going around in my head and one was related to a comment earlier around being too busy to think about discharge process stuff. That rang a bell for me. Managers are often thought of as too bloody busy to think. It is full on all the time. You think about the next two hours. To think about the next day is a goddamn luxury. That is a very odd parallel that you triggered then and why is that? To what extent is it our own problem that we generated? To what extent is the health reform doing it to us with the pace of changing everything and anything? We are trying to be all things to all people.
and I think managers are as guilty of this as clinicians are and what are the ethics of that?

Manager: But if we don’t identify it, are we just reinforcing the problem? If you alter nursing business to camouflage the problems then you’re reinforcing a system that’s never going to work.

Ethics and resources are key dilemmas exposed in this conversation. We see also the way in which the conversation loops back to previous sessions and further embroiders the fabric of this ongoing conversation.

At the conclusion of Group Three two articles are given out to the participants. We had said that any material that people found that was relevant would be welcome and one CNS brought along a copy of Sally Hutchinson’s (1990) “Responsible Subversion” article. The other article, “The State and the Health Care Reform”, is by Dr Geoff Fougere, a sociologist from Christchurch, who has written widely on the reforms. This article is given out in response to a request from a staff nurse to read something on the structure of the reforms (Fougere, 1994). Summary of Group Three appears in Figure 6.3.

Group Meeting Four: “So much of what we see is a square peg and so much of what the RHA is giving us is for round holes” (Senior nurse)

There is a three-week break between sessions three and four as there was a public holiday and the group members clearly missed the usual fortnightly meetings, exemplified by this comment by one manager:

I found at the end of last week I was going into withdrawals not having this injection (the group meeting) last Tuesday, I was reflecting on the weekend why. One of the things was the, the last time we met actually unlocked some energy for me in terms of some of the connections we were making and some of the issues that we were collective struggling with. It was quite energy releasing.

This prompts several other group members to comment about the meetings when it was
"At what point does responsible subversion become irresponsible subversion"
their turn to speak in the opening round:

Senior nurse  It’s a gift to be here. I just love coming. I love the reading. I sit up and read it in bed and my partner said what is that it must be good. Can I read it?

Manager        It’s been good to sort of talk across where the boundaries were made in the past. It feels like it has been easy to talk across those. They feel they melt a bit. It’s good for possibilities for the future. It is really good to be part of that process.

Staff nurse The way it has sort of fallen into place and the events and the contemplation that I have gone on through this whole exercise has been really powerful actually.

Nursing practice becomes the focus of conversation, particularly its complexity and relative invisibility. The nurses speak richly and passionately about the care they provide or want to provide and what sustains them.

Staff nurse  Nursing to me is all about those little moments, those little things you capture, you know, that is why I love it, you can actually go in and care for patients for even ten minutes and all of those little things happen.

Senior nurse Many a time I would be on night duty. I used to walk along the ward of a night and think, I’m caring for the community, I am sure that is why most of my class came nursing.

The senior nurse tells a graphic story of a recent patient she has nursed. A patient who has had a malodourous and unsightly tumour:

Nursing really challenges you at all levels. At the ethical level, the care giving, the pain control, dealing with this horrible wound, keeping yourself together, looking after the medical people, and he had a wife who wanted to be involved but the neighbours were blocking her. Dealing with her crisis.

They speak of Benner’s (1984) “Novice to Expert” and the value of the expert’s ability to envision what could be “down the track” for the patient.

Senior nurse  It’s when you see a patient, a young woman and you know she’s got six nodes and you see the whole thing down the track. You see the whole track until she dies, this cachectic woman. You see a young guy like we had in recently. This beautiful 18 year old young guy with an unresectable gastric cancer and you instantly see that young cachectic body down the track, you see all the
agony he's going to go through. It's really very difficult And that is an extraordinary untapped resource, isn't it. That envisioning. (Emphasis added)

One of the senior nurses points out poignantly that if expert nurses become novices when their context of practice changes, so too must managers who have come from completely different environments. When they enter the healthcare context for the first time surely they too revert to being novice managers. A novel thought for the managers present.

And they speak of the frustration at not being able to provide what they see as adequate care:

Staff nurse It is a worry. The people I take home in my head are the people in the psych area (psychiatry). The people who should be admitted and we send home. I worry that I am responsible if that patient suicides tonight. The ward couldn't take him and I couldn't get a bed anywhere and there's no one to support him. That's what nurses carry around with them everyday.

Senior nurse To hold that woman through major critical health for months on end, which you do with people with burns and cancer, is a real challenge isn't it. That keeping them going, giving them hope, sticking with it, being there, taking the pain home, you know but by God it's a thrill when you see that person a whole person and they are still a person, a human being with everything intact.

The need for a nurse-lead step down unit is raised and a staff nurse quickly responds:

It would be full in two days. The “too difficult” basket would become nursings’ problems.

A senior nurse then recounted an incident in which a young doctor was describing how she was sitting speaking with a patient. The doctor then is reported to have said:

The nurse said to me, “if that is what you see your job being what do you think my job is? Are you only leaving me the tasks?” The doctor thought that the nurse was just being stroppy and just filed the information until she came to the conference, and when she was hearing what/how people were describing their practice she said to me after, “It made me realise I don't know what nurses do.” She's in her late thirties, so she has been a doctor for a long time, she is intelligent, well educated and aware and hasn't got a clue what nurses do, apart from some of the tasks that she sees the results of when she looks at charts. I was so surprised, but one of the things that that brought home for me was that I think a lot of what we do is invisible to those who we think understand.
The managers at this point concede that they have only the sketchiest idea of what nurses really do and that they have valued the frankness and intimacy of the conversation about caring for patients that has been shared. It appears to be a moment where everyone is on the same side of the chasm and interestingly, immediately the conversation moves to the “othering” of the RHA as “them” now that the group momentarily has become “us”.

Senior nurse  The current dilemma that we have with the RHA and the health reforms nationally is very much the root of it all. So much of what we see is a square peg and so much of what the RHA is contracting with us for is a round hole (Emphasis added).

Continuing the highly descriptive turn of phrase that is so common to nursing, the work being done within the CHE on nursing workloads is described by one senior nurse thus:

I said: “Oh you crazy buggers. You’ve got the completely wrong measurement. You’re using a crescent to tighten a screw” (Emphasis added).

A staff nurse in describing the interaction between the community and the RHA says:

I know, in a sense that because they are the taxpayers, they are purchasing our services but they don’t have any control over what services are purchased. It’s the RHA that controls that. I don’t think there is a trust or communication between the community and the RHA.

Manager Has the RHA gone to the community lately to ask them for their opinion?

Staff nurse The RHA couldn’t give a toss about what they (the community) want, they couldn’t give a damn about community input into making a decision and as to holding a community public forum, why hasn’t it happened? Probably because the reins from the politicians to the Board and the Chief Executive is so short and tight that they would only play that card once and you’d be likely to have a new Board and a new Chief Executive. They would perceive it as politically trying to undermine the government view of the world. So it’s the last card you play as you look for your new job.

This potent speech from the manager sends a chill through the room. It appears to be finally the case that when the manager speaks of the vulnerable position they are in the nurses actually hear what is being said rather than taking only those aspects of the conversation that are directly
applicable to nursing. In this new position of attending to the managers’ situation frankness continued:

Staff nurse  So why are the CHEs paying for these business consultants?
Manager  Because politically it is the right thing to do. What I mean by that is, we are partly told to do it.
Staff nurse  By whom?
Manager  I guess the government agencies basically, I mean if you think about the history, the new managers came in because the old managers were garbage. Where the new managers are seen to be failing we have to notch it up a bit and spend half a million dollars just to get some mega-consultants coming in, to basically tell you what you already know. But up to now, politically, it has been the right thing to do. You get in the big guns. But there have been two or three CHEs now where they have done that and it can’t be followed through. It’s just fallen over. XX CHE got some overseas group in. They went bang, bang, bang and they left and in six months it was all dead, because they didn’t know the context.
Manager  Be aware there a number of chief executives under enormous pressure. A number of chief executives have gone one way or the other. And one of the moves if you are under that kind of enormous pressure is to set up a backstop, preferably to make an external backstop, so if it all falls apart, you can point the finger and say it’s got nothing to do with me. It’s those idiots who came in to try and do something. So part of it, from the Board’s point of view will be to build into it something that will distance it when it all goes wrong so you can find a way out without getting egg on his face. I know it sounds a bit unfair but I mean it’s human nature dictates and that would be one of the mechanisms.

All participants have shared much more intimate stories in this session and the feeling in the room is one of connection. The frankness about the external environment has been thought-provoking for the nurses and the managers have felt heard for the first time. The communication has certainly reached a new level during this session and all participants acknowledge this in the checking-out.

Group Four has both deepened the conversation about nursing practice and broadened the conversation to include the external environment. The spirals are truly in evidence as topics brought out in sessions one and two are developed further. See Figure 6.4.
FIGURE 6.4 GROUP MEETING 4 SUMMARY

"Square pegs and round holes"

Management vulnerability
External environment - Government & RHA - Community
Explaining nursing
Frustration at not providing appropriate care - Coping
Complexity & invisibility of nursing
What sustains nurses

CHECK IN
CHECK OUT
Group Meeting Five: "It's the little things that break the camel's back" (Senior nurse)

Conversation in this meeting moves from the intimacy of practice stories from both nurses and managers of the previous week, to the location of that practice in the reality of the new competitive, contestable, contractual environment. The conversation involves talk of cost shifting, the costs of the changes to nurse and patients and burnout.

Staff nurse Thinking about the values of the organisation last week and the history of the hospital, it is like the new management have dreamed up values. Nursing is built on such strong values of human caring and we have never been without those values, but lately I feel like a fiddler on the roof, you know how he had to decide whether he would let his daughter go off to a different culture. He was battling all the time with his beliefs but he was trying to be open to the new ideas. I don't know. I'm trying to be open to the ideas. It is very tiring.

In seriously looking at her role in educating new management about nursing values and the value of nursing she says with some exasperation:

In your day-to-day work you wonder why you have to take time, time and again to try to explain nursing but when you come up against the health managers I can understand why I need to but it is very tiring.

For the nurses the difficulty in trying to stay true to one's values is exposed by comments such as this by a senior nurse:

We are articulating a lot of values in this organisation, we are I think compared to some years we are a lot further down the track of sharing our views and ideas. We do have a language in which we can express these ideas. Some of the language is very fashionable, some of its is empty, some of it is politically correct and some of the language has the power to accurately reflect, but it can also, in different contexts, be used as a petticoat on the hard nose cost effectiveness agendas. So it is hard to feel really comfortable sometimes. Sometimes you have to really detach yourself, really look at the way that I interact, are these my ideas, feelings, are they influenced by what is happening? (Emphasis added).
For some nurses in practice the values clash is too great and leaving is their response. One of the EMT had left the week of Group Five session:

> It was funny the other day when xxx said about the manager leaving from the hospital “They will be sad to lose him because he has done a lot for the hospital” and Dr X said “What! He has only been there a second, and we have been fighting this battle for 20 years.” This is the thing, I think people should be congratulated if they stick at it, there are some real heroes around here.

The group recollects the loss of two of the nurses who had begun this research journey with us. They wonder aloud at the similarities that might be found in other places:

Senior nurse  

> XX has just left here to go there and people leave there to come here. The grass is always greener. I think maybe it’s all artificial turf, none of it is real. (Emphasis added).

The gulf between intention and reality in the reforms is revisited with the conviction that the RHA has only dealt with the simple contracts and has no idea how to deal with the very complex, long-term multi-pathology cases: the complex cases that no one would ever attempt to contract for and which the private sector never touches or transfers to the public sector when things go wrong. The false economy of the reforms is evident at both macro and micro levels. The service team budget holding is seen as undermining the collegiality and collaboration which had been prized at the hospital and has been seen to negatively effect the quality of patient care:

Senior nurse  

> It’s funny. It is the little things that break the camels back, because it is true, it really hurts to hear somebody didn’t get their antibiotics in Cas because it would be on the Cas budget...you know all that sort of shit that goes on. It does happen. They write it up in Cas but don’t give it until they get to the ward so it’s not on their budget. And then I get into all that sort of subversive behaviour about seeing Mrs xx and knowing she won’t fill the script because she can’t pay for it, so I give her tablets to take home and Mr xx who won’t buy a dressing to put on it so I send him home with some dressings otherwise he’ll be back in with an infection. But that’s not seen as alright.....The patient is given a script for their asthma inhaler so they can have it taken to the chemist and then brought back to the ward so they can use it. They have to pay for it. That hurts as a nurse, that hurts.
The lack of any real sense to the reforms is compounded for the nurses when contracting is explored further:

You know it is just a typical thing. We have no money left for choly's and we had this jaundiced man. He is so sick, he is confused and as soon as he settles his infection down we have to do a choly on him but he is actually going home and I said to the doctor, he needs a choly and the doctor said oh don't worry we'll just bring him in as an acute abdomen.

The nurses see this action as extremely short-sighted and lacking in a sense of responsibility for real provision of health care for people. One manager agrees regretfully saying:

The pressure is such that you can't think of creative solutions. You have to do the short-sighted solutions.

Senior nurse This is again that thing of that lack of responsibility of the new world we are in, you know they pick up the guy at the side of the road, resuscitate him, here he is, this is your problem now, that again is where I don't know if it is the nursings' responsibility but it is the one we are landed with, be it your burns patient, be it your psych patients.

The wear and tear of these responsibilities and changes which are accommodated but which do not improve practice are elaborated:

Staff nurse We have endured and endured, I have endured more than ten years of this and how much more can we take?

And the session ends with one of the more interesting challenges being posed by a nurse to the nurses:

Nurses have been saying the same thing over and over again for the last ten years, saying it to each other but have we been saying it to anyone else like our employer? Food for thought.

See summary Figure 6.5
"It's the little things that break the camel's back"

Nurses speak only to nurses

Responsible Subversion

False economy

Coping -leaving

Language

Explaining Nursing

Cultural clash nursing vs management
Group Meeting Six: “We take a one day at a time approach, AA steps to survival” (Senior nurse)

In the intervening fortnight the external environment has again become unstable with the end of the budget cycle close, and lack of clarity from the government on what changes will be made to the next funding round. The session is influenced strongly by this right from the opening round during which one senior nurse says:

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\text{We take one day at a time approach, AA steps to survival ..... so much of what we are trying to do at the moment has been put on hold \ldots\ldots. It is a hard time and I think it is impacting nursing, our staff are being sent to other wards and nurses hate that. It's a really trying time. The actual cut throat politics that are going on and I mean I suppose, as a nurse, you feel people are better than that.}
\]

The failure of the Public Health Commission to determine the minimum health care provisions any New Zealand citizen could expect has had the de facto effect of leaving the health care rationing to a budget process. This situation the nurses in particular find very objectionable and this affords much discussion.

Staff nurse You still have your acute admissions and injuries that still come in and are still treated in the best possible way, which is what keeps us going, I think, being able to practice the best way you can on each individual person. The economics of the ward situation don't affect the care we give the patient.

The rationing of health care resources inevitably raises the dilemma of best treatment for whom, the individual or the population and again this dominates the conversation.

Staff nurse I am just thinking what does that in best practice mean? Best practice for the individual, best practice for, on average for the 140 000 population that we try and serve.

Resource manager (with nursing background) It is all of that. But if I were wearing my nursing hat I'd probably be saying for the individual but wearing a managerial hat I'd have to say for the whole.

Staff nurse Here in NZ nurses are socialized into focusing on the individual whereas if we were nursing in India or Africa we'd be seeing the whole public health thing, the population.
Manager  I didn’t actually think that the current RHAs are ever going to be able to get down to a fine understanding of what is best (healthcare) practice. Be that a gold standard, a silver standard or a bronze standard I don’t think they are ever going to get there in the foreseeable future.

Senior nurse  It is certainly lack of clinical knowledge (in the RHA) but I think also they sit up in the clouds to a large extent. What clinical people have they got at the moment, plus they are guided so hard by financial imperatives.

This mismatch between community needs and what the CHE is funded for continues and broadens as one senior nurse provides one of the most poignant statements of the research:

The problem now is that you might have a starving child and he falls off his bike and you can get him a CT scan but he can’t get enough food. That relationship between social and health doesn’t seem to be working. (Emphasis added).

This hard reality is further underlined:

Senior nurse  Theoretically the RHA they should be doing community surveys and need assessments.

Researcher  Why aren’t they, are they buck passing?

Manager  I think the biggest buck passing is between the Ministry and the RHA. The Ministry on one hand saying “the RHA, you make purchasing decisions according to your knowledge and the community you service” and all those kind of statements. I suspect the reality is that the government is saying to the RHA, “Your funding is capped, you will have 5% less this year, and 5% less the following and just do it”. And facing that the RHA are paralyzed to make any rational decisions about what’s a priority and what isn’t. They just pass it all down to the CHEs.

Senior nurse  When does the CEO pass it on down to the service team management?

The need for nurses to have an understanding of the political process is now discussed:

Staff nurse  It’s not enough for nurses to just stand beside the patient. We are being challenged all the time to be responsible for economic things but it is not enough to just say we are with the client and are client focused, the system has been changed. Nurses have to keep looking after the client, as well you have to keep looking away from the client and towards the organisation... In the old days you had managers who protected the environment so the nurse could look after patients but nowadays nursing aren’t being protected anymore. They are being challenged, confronted all the time to change and be different, to be more cost effective. So it isn’t enough for nursing anymore to just focus on the client. I’d love it if it were.
And the conversation cycles back to nursing, what it is and what it is not. Again the frustration is apparent with nurses feeling they are constantly asked by managers to define and defend what they do:

Senior nurse  *I have been trying to explain what that expertise is that a nurse has that is so indefinable but that makes such a difference to the patient and I just go back to Benner. But then I ask the question, well how does a manager describe their expertise, and It's probably very similar, and it's probably just as hard and just as impossible but the difference is nobody ever asked managers. You are always asking what value is nursing. But why aren't we asking managers what they do? I guess I get sick of hearing that asked of nursing all the time and I get quite despairing that its always being asked.*

Staff nurse  *We are translating life experiences to our patients so that they can understand what is happening to them, translating literally what the doctor breezed in and said and walked out again. There are a heap of things that in a clinical facility we translate as well as doing the doing.*

See summary of Group Six conversations in Figure 6.6.

**Group Meeting Seven: “the pastry left (after the cookie cutter has been across it) is the linking bit, nursing is the linking bit, the ‘in-between space’” (Senior nurse)**

Senior nurse  *At the level of nurse-patient relationship every second the tick, tick, tick we are going further into the red and there is pressure on us to save money at every turn. How do you justify every staff member? And here we have the management team and they are above that, they are not actually connected to the clock ticking or the cash register bonking or jamming. We feel the urgency to address the problems and we feel management have a luxury of forming their “vision”. You see staff battling with maintaining that person's dignity, maintaining the caring, doing the job and you think “well how do you explain the dollars and cents to them?”*

Senior nurse  *If you've never defined this thing you call your profession and you know that people are coming in and circling things and leaving you the left over pastry after the cookie cutter has been across it then you start to get somewhat paranoid and I think that that's partly what's happened. And maybe that's it anyway. The pastry left is the linking bits, nursing is the linking bit, the “in-between space” (Emphasis added).*

Staff nurse  *(Doing the tasks) was a lot of what we were taught in nursing school and what they are not seeing in polytech graduates. They are taught other ways of establishing a caring relationship but we are often judged on the means, the tasks, because that's what can be seen.*
"We take a one day at a time approach, AA steps to survival"
The complex job that was undertaken by the old charge nurse is contrasted with the supposedly new position of "case manager", a position management saw in action in the United States.

Staff nurse   The old charge sister was absolutely a case manager. She did call the other health professionals in when they were needed.

Manager (Non-nursing background) I don't actually have a problem with what you are saying but in reality to meet the needs of people whatever the context or situation is actually enormous. Taken like that, "it's a process of working in partnership with people to enhance the health potential of individuals and groups responsive to the reality of their life situation". Now that's phenomenal and it's a lovely sentence but it's a phenomenal undertaking in our culture and society.

Staff nurse   And yet 99% of nurses take that on, which is part of why I think we go home with burdens. I think we do take it home, anger, and guilt. I don't think its necessarily healthy, I don't think its necessarily the best way but it is what we do. It is what we take on. (Emphasis added).

Senior nurse   Can I answer that with a story? (Emphasis added).

Having just been told the most detailed story of an old man and his complex situation which had involved nurses coordinating all sorts of community help and culminating in the nurse saying: "and he still had his dignity and the district nurse was not shocked and she quietly managed him., the non-nurse is drawn to say:

In this current atmosphere if something like that is fed back to the boss "nurses are going home to feed the cats and stuff" "what the hell are nurses doing?" would be the response.

Manager   The pressure is such that you can't think of creative solutions you have to do the shortsighted solution.

Management and nurses now appear to be on a collision course.

We are here as CNSs and there are a very large number of professionals with a lot of experience, great skills. A cohesive group of people. These are people who are also very creative and are actually essentially behind the organisation and where it's going and who want to be involved. Part of it, and it's to do with the fact that we spend a lot of time thinking creatively about nursing practice and what we might do and in our area because of the merger, which came about to offer a seven day gynae service, and whenever we come up with a creative
idea, creative solution, there are always so many obstacles in the way to getting somewhere.

In expressing the frustration at staff having to work in areas for which they do not feel competent or confident one staff nurse says:

The doctor said: “The thing to do is that we don’t operate in winter because that’s when all the medical beds are needed and so the nurses in the surgical ward can look after the medical patients” and I said “Well then the surgeons can become physicians and look after all the medical patients in the winter”.

Senior nurse: Something that Sandra said the other day is that some of the nurses are beginning to feel squeezed because they still hold to their ideal of working in this way with their patients, now they have been able to maintain it but only bearing the brunt and being the buffer themselves. Colleen said last week she was still able to practice as she should realistically because really sick people kept coming in and but when the practice has to change that’s when nurses feel their professional integrity called into question but the problem is that they don’t have experience in knowing what to do then and that’s one of the crunch points, They either take the shit home and talk about it at home or they leave. So how do we get them to hang in there and not take on the anger themselves but work in a way that helps them do what they need to do for their patients. Now one of them is going to be related to whistle-blowing, how do you start to act as a patient advocate beyond the one to one. This is the CNSs dilemma.

Staff nurse Management aren’t probably aware of the distress and the trauma and shock that patients experience when they are shoved out of their ward over the weekend, and they just get used to us and they are sent back again. The relationships that are created with the staff and the other patients are lost.

Senior nurse We say we add value but we can’t describe the value we add One of the things that’s happened in the past when nurses haven’t been able to practise as they feel they should is that they treat each other worse, or they take their problems home or they leave. I am yet to see nurses find constructive ways of living up to their belief that they are patient advocates. What do they do beyond stamping their feet? What else can they do whilst remaining professionally responsible?

Senior nurse If no one has got any figures then on what basis is the decision being made. Is it just about power of argument or personality?

Senior nurse Yes well it is. They go on with arguments of growing through the pain.

Senior nurse to managers You’ve got to value your nurses and respect the work that they do

Manager Because the drivers for this (a nursing understanding of what should be offered to patients) is at the one % level and they have 99% other drivers, financial, political, that entirely distracts you from the patient.
On this depressing note of reality we begin the final round. Everybody expresses their regret that we will not continue to meet as part of the research but also express their appreciation for the experience as captured by these three examples:

Senior nurse  It's been really worthwhile. It's kept me inspired. It's been a very grounding experience in a very difficult time.

Staff nurse  I found it very thought provoking and I've spoken about what we touch on with other staff nurses. We really don't talk about very interesting things at work I've realised. You stay very insular. It's been really scary at times and thought provoking and I'll really miss it.

Manager  It's been inspirational particularly when struggling with the change. Connections made across the chasm have been very heart-warming for me.

As we leave there is a strongly expressed intention for the group to keep meeting despite the research component being finished. See summary of Group Seven in Figure 6.7.

**Interpretation in Action Research – within, between and after the group components:**

The interpretations of the group component of the action research are the analyses that take place by the group reflecting in and on the outcomes of each cycle, in this case our fortnightly meetings. The reflection on the data of one cycle becomes the data that informs the next phase. This is clearly demonstrated through the diagrams of this chapter, where we see the re-visiting of themes from one cycle to the next. This is captured in summary in Figure 6.8. The movement in the focus of the conversations and their broadening and narrowing is depicted in Figure 6.9 such that the overall processes takes on an accordion or squeezebox effect. The conversations were broad but somewhat shallow to begin with, as one would expect. As the conversations deepened they focused more on the nurse and the patient. When group rapport was well established the conversations were able to become more expansive encompassing the range of issues from patient to context without compromising the depth of the conversation.
"The pastry left is the linking bit, nursing is the linking bit, the in between space."
FIGURE 6.8
THE COMPOSITE PICTURE OF THE ACTION CONVERSATION

GROUP MEETING 1

GROUP MEETING 2

GROUP MEETING 3

GROUP MEETING 4

GROUP MEETING 5

GROUP MEETING 6

GROUP MEETING 7
FIGURE 6.9
THE MOVEMENT IN CONVERSATION ACROSS THE GROUP MEETINGS

1 Managing patient care - day to day nursing practice
2 Managing wards
3 Managing the hospital
4 Managing within the health system
An interpretation of the concerns of the nurses throughout the group work can be summarised by looking first at the concerns related to the context of practice, akin to Carr and Kemmis’ notion of the “situation in which practice takes place” (Carr & Kemmis, 1986, 165), followed by a summary of their concerns directly related to practice.

The nurses concerns related to the context of practice included:

- The inconsistency with which economic restrictions were applied and the false economy of many management practices.
- The lack of congruence of expectations of government, the RHA, the hospital management, the nurses, the patients and their families, and the community of the health services that would and should be provided.
- The inappropriateness of the application of a market model to healthcare. They raised the myth of competition and the lack of information to enable accurate contracting. They discussed the turbulent nature of the external environment, and their enhanced appreciation of the vulnerability of the CHE managers to these changing external pressures.
- The incompatibility of philosophy of leadership, management and the organisation of health care services between management and clinicians. The nurses saw a more consultative, collaborative, more inclusive model as appropriate rather than a hierarchical one in which a group of senior people make the decisions and the workers following instructions.
- The sheer exhaustion of incessant environmental change.

The nurses’ practice concerns included the following:

- The differing ethical positionings of the managers and nurses. The nurses clearly aligned themselves morally with the patient, whilst the managers appeared aligned to the role of the organisation and through that indirectly to patients as the group receiving the services for which the company had been contracted to provide.
• The invisibility and complexity of nursing. This was demonstrated in the repeated raising of the need to explain nursing to successive managers and politicians, and in the difficulty for managers in being able to account for nursing in budgets through staffing or patient acuity systems. This was captured graphically in the senior nurses comment “You’re using a crescent to tighten a screw”.

• A level of professional malaise and frustration. This was evident in the way the nurses discussed both their own coping mechanisms and those of their colleagues, by leaving for greener fields only to find them “artificial turf”, by leaving nursing altogether, by taking the “baggage” home and by talking, talking and talking within nursing about the difficulties.

• Changes to the process of practicing nursing. This was necessitated by the increase in casualisation and the short-staffing. It was impacted on in subtle ways also by the budget constraints on equipment and resources generally.

• Fears for patient safety. This was demonstrated through concern over staffing levels, and early discharge to an under-resourced and unprepared community that held different expectations of the role of “their” hospital. It was expressed also in the worries about patients that they “took home” at night with them in their hearts and minds after their shift had finished.

Fear for patient safety and wellbeing was at the very heart of the nurses’ discontent.

Postscript:

The follow-up meeting discussed as such a positive idea at the end of Group Seven never happened. As the time approached for it to be held individual-by-individual gave apologies for other more pressing commitments. This was not really surprising but was very reinforcing in relation to the importance of the structure and commitment that is brought to a work unit by a research process.
Within six months of the research the senior nurses, who had been meeting regularly, had formed a steering committee for the R.H. Nursing and Midwifery Development Project. This project developed strategies around the following key issues: workforce planning and utilization, nursing care delivery systems, workforce/professional development, leadership for nursing and midwifery, management style and communication, employment relationships, professional issues and the relationship with other health professionals. The final report went to the CEO and the Executive Management Team. The report recommended a career structure for nurses and processes for communication (within nursing and within the hospital as a whole) and it recommended the re-establishment of a formal Director of Nursing position. These recommendations were supported. I have no way of knowing whether the action research process helped to move the nursing staff to take such an active leadership role, but anecdotally, I have been told it was a catalyst. There were several of the action research group in leadership roles in the new project.

Within this same time frame the CEO had left, replaced initially by an Acting CEO and then a newly recruited CEO and two further General Managers had resigned. There had been yet another restructuring, citing the following problems in the "old" structure: "blurring of roles and accountability; managers with power but little connection to the frontline staff; decisions slow and not integrated; lack of leadership; professional clinicians tied up in administration; and high costs." (Information Pack: Management Structure Redesign, June, 1996).
CHAPTER SEVEN

Interpretation:

Coming To An Enhanced Understanding

_Picking up the heartbeat_
"I am made between land and sea in the tides of Tangaroa"
Sculpture by Cuan Forsyth-King
Dept. Of Nursing & Midwifery
Victoria University of Wellington
CHAPTER SEVEN

Interpretation in Multiple Layers:

Within this study there are multiple layers of interpretation. The first interpretive layer is the action research process itself, with its in-built group processes of analysis both within the group and between group meetings. Throughout this process I was a participant/researcher and co-contributor to the interpretations. These interpretations were the substance of Chapter Six. Secondly, there is the analysis that occurs immediately following the action research group process in order that the outcomes or findings might be recorded. In this process my role switches emphasis and I become predominantly the researcher. This interpretive process is the one described by Susman and Everitt (1978) as “specified learning” or the identification of the general findings of the group work. The voice in this interpretation, whilst influenced by the experience of the group, is nonetheless my own. This interpretation is displayed in the summaries I have constructed of the group process at the conclusion to Chapter Six and diagrammatically represented in Chapter Six in Figures 6.8 and 6.9.

The third process of interpretation within this thesis is that of critical reflection on the process and findings of the action research, together with the exploration of the healthcare and nursing contexts elaborated in Chapters Three and Four. This interpretation, as with any hermeneutic study, remains that of the person who is engaged in the process of interpretation and is, thus, my own, constructed whilst standing, (and sitting and walking) around on my own, distant geographically and temporally from the New Zealand nursing of 1995/6. Throughout this prolonged process I have been engaged in a more reflexive analysis of the research question and its outcomes as they inform and are informed by the contemporary context of healthcare
internationally, some seven years after the action research; a seven-year cerebral itch if you will. This interpretation reflects multiple fusions of multiple horizons as the hermeneutic circle refused to be broken until the time of the writing of the thesis. The work has been carried on a journey across countries, into and out of scholarly and practitioner forums and finally here into written form. A list of publications and presentations relevant to the formation of this thesis appears in Appendix II. The processes of this third interpretation will be laid out in this chapter and tensions exposed within the nursing practice environment which, I believe, hold a key to determining how nurses might be better able to practise in future. Such future practice would be without the moral burden or compromise we have witnessed through this study.

**Re-interpreting the Data:**

Shortly after the completion of the action research phase of the study I began a re-analysis of the transcriptions of all the interviews and the group work using the traditional social sciences “cut and paste” method. The interviews were first coded according to a priori codes resulting from the questions asked of the participants, as the interviews followed a semi-structured approach. They were then coded according to ideas and issues that arose from the data where the conversations introduced elements not captured by the a priori codes. The process used was similar to that which may be used in grounded theory for the initial rounds of coding (Glaser & Strauss, 1967; Strauss & Corbin, 1990). This provided a comprehensive reconnaissance or overview of the issues and concerns of the group as they entered into the group work phase of the research. The concerns expressed in the interviews are discussed in full in Chapter Five.

The outcomes of this analysis were then combined with the group work findings. The tapes of the group work had been separately analysed using an approach discussed in Chapter Two named by
Winter and Munn-Giddings (2001) as "dilemma analysis". As the group discussion generated such a large data set, analysis was conducted initially using the dilemmas identified within the action research process itself. The next step was to look at the summaries that I had made of the key points of each session and any additions or modifications suggested by the group at the subsequent meetings. The data were then scrutinized for any other dilemmas that were not highlighted at the time of the meetings but which had clearly been part of the discussion. This refined searching revealed a greater depth and breadth to the group findings.

The issues apparent from this combined group and interview analysis were found to relate to:

- Loss of nursing voice and leadership
- Loss of nursing's control over practice and the practice environment.
- Accounting for nursing practice – how is nursing work judged, valued and costed?
- Resourcing for adequate patient care (staffing, casualisation of the nursing workforce, equipment)
- Nurses in the "in-between" space – buffering, translating
- Communication – "who cares?"
- Language – language of management, lack of clarity of language of nursing/ nursing's metaphorical language.
- Trust – "them" and "us"
- Responsible subversion – in whose interest do we act? - Competing philosophies of care
- Change fatigue – management musical chairs
- Flaws in the system- false economy / uncompetitive competition.

This framework was helpful in understanding the situation of nurses and their experience of the reforms but I was unhappy that it still did not provide access to a positive direction forward for nursing in times where nurses believed their ability to care was compromised.
Personal and professional circumstances then intervened and delayed the writing up of this study for nearly five years. During this time, however, I could not put the work down. The hermeneutic circle would not be broken and I walked and walked around with the story speaking about it at many different nursing and healthcare forums, including national and international professional conferences at which I received feedback from strangers who strongly connected with the story. This process of speaking publicly about the research both further clarified and challenged my conceptualisations. As Gadamer (1975) suggests, interpretation is ongoing and influenced by the interaction of new and old experiences and understanding. The circle of interpretation was engrossing.

Throughout this time of reflection and reinterpretation I was amazed and professionally dismayed to find that, in the study, were the human voices to the dilemmas that have appeared in the nursing literature from many countries in this intervening period. This realisation strengthened my resolve to tell the story, to put it down on paper. Not only did I believe the story worth telling for its own sake, as well as wanting to honour the gift given to me by those people from R.H., but I strongly believed that the resonance of the voices from 1995 with the contemporary situation made the warnings, pleas, suggestions and admonitions of the group relevant to a broader audience, albeit coming from that now somewhat distant time and place. In doing so the responsibility is not just to the retelling of the story and the process, but also to the development of a schema for nursing practice that enables nurses to continue to provide care, irrespective of circumstance, in a way that does not leave them paralysed by a moral burden and with no apparent influence or agency through which to change the situation.
Re-forming the Circle:

I immersed myself once more in the study by entering all the data into N-Vivo, a qualitative data analysis software programme (Bazeley & Richards, 2000) and re-analysed the data using the same strategies I had previously used by hand. The codes determined in the initial analysis were entered and the node trees grown with further data analysis. Examples of these node listings appear in Appendix I.

Whilst capturing a rich and thick description of the categories of what was said, the development of these categories still did not enable me to feel I was getting to the heart of the story. The original aim which was to positively affect change in practice, understanding and the situation of practice for nursing remained, now somewhat delayed and broadened.

N-Vivo has qualities far beyond the data holding and handling capacities I needed, most of which I did not use. The modelling function, however, was the one I found most helpful. I am a strongly visual person and prefer diagrams and maps to large volumes of text. I mentioned in Chapter One the work of Usher and Bryant (1987) who spoke of the need to be able to move the conceptual furniture around at will. The model-making function of N-Vivo allows the researcher to do just that. The researcher no longer has to rely on holding complex mental images and trying to modify them in one’s head. The program enables one to move elements around and to reflect on these modifications and make further refinements. (See modelling examples in Appendix I). The models enabled me to see, literally, that much of what had been coded and classified were descriptions of the moral tension the nurses experienced as they tried to accommodate the management requirements without compromising patient care. Where patient care was felt to be compromised the nurses described their responses to this intolerable situation – they left, they
experienced or engaged in hostile staff interactions, they engaged in what the research group had come to name “responsible subversion” or they gave up the moral ideal of caring and just concentrated on getting a “job” done for eight hours and going home.

Having now “seen” the link between the nurses’ concerns, the changes to practice, and the nurses’ responses in trying to cope with these changes, I felt the need to listen to the tapes all over again. I listened to the tapes whilst reading the transcripts and the code files and looking at and modifying the models/maps. In doing so I was reminded of Gadamer’s commitment to the performative aspect of interpretation and to his suggestion that reading aloud “awakens a text and brings it into new immediacy” (1992, 399). Here I would suggest an audiotape fulfills Gadamer’s suggested auditory stimulus. Not only was the text awakened in the process, but I was flooded with memory of the sight, sound, smell and passion of the interactions. I could “see” the body language and hear the tensions and the laughter. Through this process I became confident and secure that I had grasped the key messages of the participants albeit drawn through time.

**Once More Around the Circle - Finding the tensions:**

The key to understanding the nurses seemed to be related, not so much to the words that were being said, but to the action and feeling position from which they were generated. “Powerless”, “frustrated”, “not listened to”, “not consulted” from the nurses juxtaposed with the managers’ “why don’t they take action”, “they are the key to the whole thing working”. It seemed that so many of the conversations were people speaking from positions that held differing aims, different values, or a different perception of what was possible within the situation. Pursuing this thread it became clearer that one conception of the dynamic of the study was to see it as a series of tensions that were being exposed through the conversations. These tensions engendered feelings
and behaviours in order to ameliorate the tensions. It seemed this could provide a constructive way for finding movement from the morally "stuck" or "subversive" position that seemed to be a dominant thread in the nurses' responses described within the research.

Having re-analysed the data and moved part to whole and whole to part in self-dialogue it seemed there were four main tensions at work that helped me make sense of the nurses' frustration. All four will be exposed and then each will be explored in greater depth for their implications for the positioning of nursing within the study and their direction for a positive way forward for nursing and hence patient care.

The first tension to emerge was that caused by the difference in the focus of the role of the nurse and the manager. They both believed their role was the provision of healthcare but the tension arose in the focus through which they enacted their role. The nurses' commitment was to provide the best possible care for the individual person who was the patient being cared for by the nurse at a particular moment. The focus of the nurse was on the development of an effective nurse-patient relationship and through that relationship to meet the needs of that particular patient. If the patient's needs could not be met the nurse felt her care had been compromised. The nurse bore a burden of responsibility for this, as she perceived herself to be the care provider and care co-ordinator. Her covenant was with the patient.

The focus of the nurse was juxtaposed with the management focus. Management was focused on the organisation of the institution through which care was provided. Within the New Zealand context of the time of the study, this care was to be provided through a contestable contract for services between the RHA and the CHE for a defined number of procedures for which a defined
budget would be provided. The care was therefore a commodity to be organised on behalf of a group of service recipients who were known as the customers or the clients rather than patients. Given the financial constraints in healthcare at the time, this inevitably required a degree of rationing of care provision in order to provide adequate and safe care within the nominated budget for a diverse range of people. The result was a dissonance of professional cultures.

The second tension was similar to the first but at a broader level. It was a tension caused by a difference in the understanding of on whose behalf the service was being provided. The nurses believed they were serving a community with the attendant commitment, loyalty and interpersonal engagement. Here confidentiality was important and its focus was a respect for the patient. This was juxtaposed against the management understanding that they were working for a business-like enterprise, governed by a board who were in turn responsible to a performance-monitoring agency (the CCMAU discussed in Chapter Three). The managers' work was governed by the setting of contracts with measurable targets and defined budgets. Management of the company drew on a set of generic management skills in organising the business processes and the workers in those processes. The nurse was seen as a worker, working for a company whose mode of operation necessitated notions of competition and contracting, and therefore adherence to policies on how the business was to be conducted. Here too confidentiality was important, but the focus was not on the patient but rather on the "commercial-in-confidence" nature of the business processes.

A third tension was generated from the conflicting management and leadership styles preferred by the nurses and those in management positions. As indicated earlier, the nurses stated a commitment to a model of shared governance and collaboration, with an emphasis on
enhancement of the quality of care. The quality focus for managers was on efficiency of systems and cost effectiveness of processes rather than on care: a management commitment to target setting and performance measurement dictated by a contractual agreement set in an environment of competition. The driving force was the provision of services controlled by a process of budget setting. There was tension caused by the decisions related to the allocation of resources. Immediate needs conflicted with ideas of longer-term investments. It was a tension born of a lack of coherent and explicit vision for the institution and thereby a lack of agreement to a common course of action or behaviour. The perceived need for a coherent and explicit vision was at the cornerstone of the tension related to leadership. The question arose: leadership for what, by whom and expressed how?

The fourth and final tension involved was simultaneously the most complex and yet the most simple, and its roots were strongly embedded in the other three. This was the tension caused by the discordance of expectations: the expectations of patients and their families; the expectations of staff nurses about roles of everyone who they perceived to be above them in the company structure; senior nurses confusion about their authority, accountability and role boundaries making their expectations of themselves unclear; the expectations of managers about their interactions with staff, and their interactions with an external environment in which the expectations and “goal posts” kept changing; and the expectations of communities about healthcare provision and the role of their hospital. It was in relation to expectations that the different speaking positions, different aims, different values and different conceptions of what was possible became most obvious. This is perhaps not surprising as this fourth tension is a cumulative one, encompassing the build-up through the expression of the other three.
These four tensions not only captured the issues that were prevalent in the interviews and group work, but also those which had arisen through Chapters Three and Four where changes to healthcare provision and nursing were explored. The tensions also provided a framework for understanding the emotional responses and actions as described above, of the “lateral arabesque” out of nursing (Kramer, 1974), of responsible subversion (Hutchinson, 1990) or of simply feeling burdened and ‘stuck’. These tensions will be explored one-by-one. However, as there are potent philosophical differences underpinning all four of these tensions they may be seen as being interrelated and the unpacking of one sheds light on each subsequent tension.

Tension One – Managing the patient vs managing the healthcare business:

This tension is one of cultural dissonance. It arose because of the difference in philosophical alignment. The nurses saw their covenant or contract as being with the patient. On many occasions they spoke of care as their guiding principle, specifically that an ethic of care underpinned their practice.

In Chapter Two we saw that the philosophical underpinning of the public sector reform in New Zealand was one of a melding of the New Public Management (NPM) theory, Agency theory and Public Choice theory. This philosophy could be encapsulated by notions of the individual, choice, and autonomy, and the mechanism of interaction to be one of transaction by contractual arrangement. The first three of these concepts do not appear on the surface to be in contradiction to nursing beliefs. Indeed notions of the individual, choice and autonomy are frequently associated with nursing discourse about patient care. However, in exploring the meanings further we discover the dissonance. The emphasis within the government reform philosophy was on the individual as responsible for him or herself, on choice as a prized value,
but only as it applies to the choice of what one can purchase, and on autonomy as the concept that exonerates one from any responsibility for the wellbeing of one’s fellow citizens and any notion of social responsibility. The foundation of these public sector changes was a belief that people act as individuals motivated by self-interest (Boston et al, 1996). Here we have a fundamental philosophical divide emerging with nursing. Self-interest is antithetical to the focus of nursing. For nurses the focus is on interest in others. Nursing is foundationally relational and other-oriented. 

This was captured by Reiser (1990) in his work on human corporations thus:

There are in hospitals two powerful cultures whose relationships exist in tension. One is the professional culture – focused on giving care to the individual who is the patient, present-oriented because of the urgencies of illness and injury, and principally directed by values that secure patient welfare such as confidentiality and truth.

The other is the corporate culture – focused on the collective needs of the patient that comprise its constituents, future-oriented through concern for generational continuity and growth, and principally emphasizing values that insure institutional survival such as financial responsibility and duty to benefactors and shareholders (Reiser, 1990, 122-123).

In order to further understand this cultural dissonance particularly with reference to nursing it is necessary to explore the ethic of care as this is the moral basis the nurses of this study claim for their actions. This exploration will uncover why, in an environment of managerialism, nurses are left seemingly unable to move forward, weighed down with a burden of frustration and guilt.

The ethic of care:

Whilst caring has been synonymous with nursing since recorded history and documented as such from the beginnings of modern nursing in Nightingale’s writings, the ethic of care is commonly seen to have its genesis with the work of Carol Gilligan (1982) in her landmark book “In a Different Voice”. Here Gilligan challenges the orthodoxy of the primacy of the ethic of justice as
the moral framework and suggests an alternate mode of understanding moral interaction by focusing on relationship, not of hierarchy, but rather as a web of connection.

The ideal of care is thus an activity of relationship, of seeing and responding to need, taking care of the world by sustaining the web of connections so that no one is left alone (Gilligan, 1982, 62).

Gilligan concludes her book by suggesting:

While an ethic of justice proceeds from the premise of equity – that everyone should be treated the same – an ethic of care rests on the premise of nonviolence – that no one should be hurt (Gilligan, 1982, 174).

Care and justice are put forward by Gilligan as two moral perspectives related to thinking and feeling which enable a person, male or female, to take different kinds of actions within both public and private life. Prior to Gilligan’s work the emphasis within ethics had been on a rule-governed justice based moral framework which was seen to govern public life (Kohlberg, 1981; Gilligan, 1982). Gilligan has been much criticised for creating a binary of men’s and women’s ways of being moral. However, Gilligan clarifies this by insisting that she did not call the book “In a woman’s voice” but rather “In a different voice”, raising the difference in the way in which the group of women she was studying differed from the group of men studied by Kohlberg. Both groups were predominantly white and well educated, as they were students at Harvard in the late 1970s.

Nell Noddings (1984) furthers the exploration of caring as a moral foundation in her book “Caring – a feminine approach to ethics and moral education”. Here there is no confusion. Noddings is proposing a separate feminine or women’s ethic. The ethic proposed here is said to be an extension of the natural ethic of caring such as that experienced by the mother. This understanding of one-caring, Noddings suggests, can be extended from the natural form of caring
to a caring for someone with whom one is not in a natural caring relationship. One can fulfill the role of one-caring for one requiring care, the cared-for. For Noddings, women, in particular, approach moral problems by placing themselves mentally and emotionally as near to the concrete situation of the cared-for as possible. From this position they assume a personal responsibility for the choices to be made as they work their way through moral problems from the position of one-caring (Noddings, 1984). Noddings draws on Gilligan in this understanding by quoting her thus:

> Women not only define themselves in a context of human relationship but also judge themselves in terms of their ability to care – (she becomes) the weaver of those networks of relationships on which she then relies (Gilligan, in Noddings, 1984, 96).

Appreciative of the potentially unequal, albeit somewhat two-way, nature of the caring relationship as described by one-caring and the cared-for, Noddings describes the conditions that presuppose the ability to provide care. She draws attention to the need for self care for the one-caring (1984, 105) and the importance of understanding what gives one pain and pleasure before one can care for others (1984, 14). She also suggests that the one-caring needs to fulfill her needs in more equal relationships in order to continue to act as one-caring.

It is not surprising then, at a time when the health care crisis was beginning to be felt by health professionals in the United States in the 1980s, and the economic rationalist turn was taking force, that nursing writers turned their attention to what it was in nursing that transcended the merely technical aspects of our work. Jean Watson's (1979) early work on caring clearly predated the work of Gilligan and Noddings but by the late 1980s the caring scholarship in nursing, philosophy, education and psychology were beginning to inform each other. Benner and Wrubel (1989) in their book “Primacy of Caring” suggest “caring, as a word for being connected and having things matter, works well because it fuses thought, feeling and action – knowing and being”. Interestingly, here they include “action” in the fusing of thought, feeling and action but
do not include it in the verbs that follow, they include only “knowing and being”. I say “interestingly” as it is the very lack of this ability of the nurses to take action and change the situation that appears to be the key to this study and which appears to be an inherent flaw in the underlying ethic of care. The nurse-patient relationship here (one-caring and cared-for) is always inward focused and it appears therefore not to enable, or require interaction with the environment in which care takes place whilst at the same time being buffeted by this external environment. Benner and Wrubel go on to say “because caring sets up what matters to a person, it also sets up what counts as stressful, and what options are available for coping. Caring creates possibility” (Benner & Wrubel, 1989, 1). Within an only inward looking ethic of care, however, these ‘possibilities’ seem constrained.

As indicated in Chapter Four, many nursing curricula through the late 1980s and 1990s took the ethic of care to be a fundamental construct of nursing practice and the vehicle through which this moral ideal was enacted was the nurse-patient relationship, a topic about which library shelves have since been filled. The nurse-patient relationship became so much the primary relationship of practice that interpersonal relationships between nurses and other health team members became so obscured that at times they disappeared, particularly from educational programmes.

Thus, by 1995, the nurses of this study spoke unequivocally about the ethic of care as their guiding moral framework, spoke of the primacy of the nurse-patient relationship and their moral obligation to meet the needs of the patient, and yet were exploding with frustration about being unable to provide the care they believed they had a personal responsibility to give. It appeared that somehow the nurses’ interpretation of the ethic that guided their practice had left them with
very large emotional burden and very little ability to productively improve the situation for the patient. This was made clear on the Group Meeting Seven exchange:

Manager: *I don’t actually have a problem with what you are saying but in reality to meet the needs of people whatever the context or situation is actually enormous. Taken like that “a process of working in partnership with people to enhance the health potential of individuals and groups responsive to the realities of their life situation” (quoting a definition of nursing given by one of the nurses). Now that’s phenomenal and it’s a lovely sentence but it’s a phenomenal undertaking in our culture and society.*

Staff nurse: *And yet 99% of nurses take that on, which is part of why I think we go home with burdens. I think we do take it home, anger, and guilt. I don’t think it’s necessarily healthy. I don’t think it’s necessarily the best way but it is what we do. It is what we take on.*

Mary Chiarella (2003) in her paper on “work ethos” and the corresponding “practice zones of behaviour” describes this behaviour as characteristic of an “ethos of individual accountability” leading to a “practice zone of isolation and alienation”. Such an ethos provokes in the nurses the responses we have so clearly seen – leaving, living with an increasing moral burden and taking it home or taking it out on each other, or acting subversively. The alternative to these appears to be a submerging of emotional engagement and just “doing the job”, with a response not infrequently heard of “It’s not our responsibility. We’re only nurses. We can’t do anything about that”. This Chiarella (2003) describes as displaying an “ethos of collective non-responsibility” and a “practice zone of abrogation”. None of these responses appears to be morally fulfilling or growth producing. What we are seeking here, in our quest for an ethic of care with agency is what Chiarella characterizes as an “ethos of collegial generosity” and a “practice zone of mutual trust and collaboration”.

This moral pincer movement or squeeze has been recognised by a number of writers such as Hochschild (1983) in her work on the emotional labour of flight attendants; Yarling and
McElmurray (1986) in their work on nurses not being free to be moral; Reverby (1987a, 5; 1987b) in her famous article on nurses being “order(ed) to care in a society that does not value caring” and does not provide the necessary resource for care; Smith (1991) and James (1992) in their respective work in the United Kingdom on emotional labour; Rodney and Starzomski (1993) on the moral distress caused by structural and interpersonal work environment; Hanaford’s (1994) critique of Nodding’s relevance to nursing; Tschudin’s (1997) exploration of the emotional cost of caring and Varcoe and Rodney (2002) again on constrained agency.

Hanaford warns:

As the nurse-patient relationships are not equal, in that the patient does not give the nurse the caring she requires, the nurse may get her “caring well’ refilled in more equal relationships. This quantitative diminishment of caring can be most pragmatically demonstrated by the nursing staff shortage. Nurses are required to take care of more and more patients. And consequently they can give a diminishing amount to each. In a very real sense, nursing is practising in a chronically ethically diminished state.....presumably the overworked and exhausted nurse is in no condition to be sensitive and caring (Hanaford, 1994, 190-192).

An exclusive focus on the nurse-patient relationship within a system of patient allocation where the nurse is physically distant from other team members, in four bed wards or single rooms, and intellectually and emotionally in that there is not a team sense of shared responsibility, there is potential to exacerbate the drain on the nurses’ ‘caring-well’ or emotional capacity. In “The Managed Heart”, Hochschild (1983) draws our attention to the commodification of emotional work where human response is sold for a wage and therefore gains “exchange value”. She exposes the consequences of exploiting emotional labour in her study of flight attendants. For Hochschild, emotional labour:

requires one to induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others – in this case (with flight attendants) the sense of being cared for in a convivial and safe place. This kind of labor calls for a coordination of mind and feeling, and sometimes draws
on a source of self that we honor as deep and integral to our individuality (Hochschild, 1983,7).

The consequences, Hochschild suggests, of prolonged exploitation of emotional labour is that the person separates themselves from their outward “face” leaving them feeling inauthentic and estranged from their integrated sense of self with a “have a nice day” and a plastic smile. But subjugating the relationship and reducing it to instrumental functioning with a plastic affect is no productive way forward for nursing. The cost to both the patient and the nurse is too high.

There are three central questions that emerge here:

- Are there particular conditions which are necessary in order for caring work to be undertaken?
- Is there something within our understanding of the ethic of care that could enable greater agency and less dependency for the one-caring?
- Is it that an ethic of care is necessary but not sufficient to form the moral foundation for the practice of nursing?

While each could be the subject of a thesis in its own right, they will each be explored briefly here in our search for a better understanding of the tensions, specifically Tension One.

Firstly, are there particular conditions which are necessary in order for caring work to be undertaken? Here we are reminded of the conditions of caring Noddings (1984) herself specified. The person must be rested and ready to provide care and must be aware of what causes pleasure and pain (Noddings, 1984). This resonates with the imploring of our senior nurse Nina who tells us that we must nurture nurses in order for them to nurture others and of the comment to me on my arrival in New Zealand that “I have never been so lacking in elastic”. There is clearly something here related to the refilling of the “caring well” that we need to take heed of. “Nurses
must be nurses to themselves first before they can really be nurses to others” says Tschudin (1997,157). In this study such self care ability is influenced by the staffing levels, staffing patterns, patient numbers and acuity levels and bed availability that was brought to our attention loudly by the nurses. The experiences of the nurses in the National Health System reforms in the UK have echoed these experiences and the need for both structural support and emotional support (Tschudin, 1997). The heart of the structural support is the need for nurses to regain control over the work environment and staffing budgets in order to provide safe and adequate care. Emotional support is at the most fundamental level: recognition of the contribution of the caring work of nurses to the positive health outcomes for patients, in other words, the primacy of their caring work. Apart from this recognition, there are many structural necessities such as clinical supervision, clinical career paths and educational support but these are all predicated on adequate conditions of work such as safe staffing levels which enable caring.

The second question exposed by our exploring of the ethic of care is then, “is there something within our understanding of the ethic of care that could enable greater agency and less dependency for the one-caring?” Sarah Hoagland (1991) has in fact explicitly referred to the ethic of care as an ethic of dependency in her critique of its lack of agency. Hoagland raises this lack of agency in the ethic of care as follows:

Female actions are to be directed towards others thus the female ability to act is located in others. Consequently, the primary mode of female agency is manipulation. And this, of course, is the stereotype men use to dismiss and criticize women when they behave in ways men have prescribed (Hoagland, 1991, 246, emphasis added).

This double bind was seen so clearly in the study in the nurses’ use of what they referred to as “responsible subversion” and the managers’ inability to understand the manipulation of ‘company’ rules as justifiable. Hoagland’s naming of the mode of female agency as one of
‘manipulation’ resonates powerfully with New Zealand nurses as in the landmark investigation into unethical medical practice, the Cartwright Inquiry, Judge Silvia Cartwright said that nurses had been conditioned to protect patients by “stealth” and this she saw as antithetical to a positioning as patient advocate (Cartwright, 1988). Not only does Hoagland believe there is a lack of agency within the ethic of care, she sees its focus as only pertaining to the private domain.

“Caring cannot be insular and it cannot ignore the political reality, material conditions, and social structures of the world” (Hoagland, 1991, 260). She goes on to say:

I question her (Noddings) particular analysis of caring because it does not adequately challenge the proximate intimate, because it fears the proximate stranger and because it ignores the distant stranger (Noddings, 1984, 47). An ethic that leaves starving people in a distant land outside the realm of moral consideration is inadequate, especially when... we have had a hand in creating these conditions. And a stance that fears the proximate stranger means the caring is not capable of crossing politically and socially imposed barriers, such as racism, to promote change (Hoagland, 1991, 260-291).

This criticism is of particular relevance for nursing in that our responsibility includes not just hospital based one-to-one care but community and public health care. Any moral foundation must be able to accommodate all nursing contexts. It must provide for understanding the mental health consequences of separation from land and language, and the health consequences of poverty and lack of education. I foreshadowed the necessity for a broader positioning for nursing knowledge in 1995 in my extension to Carper’s ways of knowing at which time I suggested the patterns of knowing be extended to include “socio-political” knowing as a relevant and distinct pattern of knowing for nursing (White, 1995a).

Feminist writing generally and feminist ethics in particular have questioned the helpfulness of the dualism created by a woman centred philosophy or ethics, as we saw in Chapter Two. In Gilligan’s (1982) case, though perhaps not in that of Noddings (1984), there was no express
intention to have the ethic of care denoted as a women’s ethic. As indicated earlier, Gilligan explicitly called it a “different” not a “woman’s” voice. Jaggar (1991) raises this issue contending:

Not only do the characteristics considered masculine and feminine vary widely across cultures and history, but in complex societies they are also typically associated with other seemingly non-gendered attributes such as class and race (Jaggar, 1991, 89).

For Jaggar, whilst a feminist ethic may begin with feminine ethics it must move beyond this position. Jaggar and Hoagland join in the assertion that for there to be a feminist ethic there must be the possibility of action and change. In this therefore feminist ethics and politics are inseparable.

Action, in a feminist ethic of care, is not unidirectional towards the cared-for by the one-caring but must also be outward-looking to the environment that controls the possibilities for caring. This linking of politics and ethics, according to Rosemarie Tong (1993), brings a revision to the time of Plato’s Republic when “an isomorphic relationship exists between the virtues of the individual (wisdom, courage, temperance and justice) and the virtues of the city” (Tong, 1993, 183). Here politics is being used not in the discredited modern sense but in the classical sense which is to “pay attention to issues of power because in doing so they (feminists) liberate themselves and others. Politics is indispensable to ethics in the sense that only an empowered person has the capacity to self-reflectively make a better world” (Tong, 1993, 183). So for nursing the essential conclusion is the necessary inclusion of a political element to their underpinning practice ethic.
The third question then, "Is an ethic of care a necessary but not sufficient ethic to form the moral foundation for the practice of nursing?" could be seen from the above as becoming: "Is a feminist ethic of care sufficient?" Here I believe the quote from Tong above provides a clue, with her reference to virtues that are inclusive of the notion of justice. There has been, within nursing, a renewed interest in virtue ethics (van Hooft, 2003; Raholm, 2003; Scott, 2003).

The concept of caring in nursing, conceived of as a virtue, transcends the debates in moral theory between the caring perspective in ethics and the justice perspective. Just as a person who evinces phronesis feels rightly, thinks rightly and thereby acts virtuously, so the caring person feels caringly, thinks caringly, and thereby acts virtuously. Caring conceived of in this way is neither merely an interpersonal emotion nor just a professional practice. It is the very ethical life of nursing (van Hooft, 2003, 11).

Raholm (2003) suggests caring is a "call to the heart rather than the mind" – I would suggest it is a call to the heart as well as the mind for nursing is lessened greatly if not appreciated for its intellect and the nurse as a knowledge worker. Raholm focuses on phronesis, which we have seen previously as Aristotelian practical wisdom. Here Raholm (2003) equates it also to an ethical perspective encompassing human dignity, responsibility and caritas (empathy and compassion).

I believe there is a combination of an ethic of justice, phronesis, virtues ethics and an ethic of care inextricably linked to a classical notion of politics, that can guide nursing to a more action-oriented caring future.

Through this exploration Tension One then takes on different possibilities. The nurse has a vision of a way of working that enables not only provision of best care for the individual patient but a way of constructing a composite understanding of the needs of patients generally. This composite understanding then is to be taken to a broader constituency, rather than the bemoaning of the situation to other nurses or feeling rejected in any approach to the next level of management. It requires engagement of the public, other healthcare providers and health bureaucrats in coming to
know that which the nurse knows. It requires nurses to engage politically. Jean Watson (1990) reminds us that when morality reaches the public realm it is called politics and when it reaches “allocation of health resources, division of professional labor, and control of practice rights, it is called health policy” (Watson, 1990, 64). Nursing, therefore, has a moral obligation by extension to its obligation to the patient to engage with health policy and the politics of healthcare.

Tension Two – Service to community vs working for the company:

This second tension moves from inside the hospital to the broader level of service provision. The nurses believed they were serving a community whilst the managers believed they primarily served the company which in turn was answerable to a board for performance. This difference in focus was disturbingly highlighted in the exchange in Group Four of the research meetings. Here the manager responds to the nurse’s suggestion of holding a community forum to engage the community in determining its healthcare priorities. The manager indicates that it would be, for any manager:

The last card you play as you look for your new job... (as)... the reign from politicians to the board and the Chief Executive is so short and tight they would only play that card once and you’d be likely to have a new board and a new Chief Executive. They would perceive it as politically trying to undermine the government view of the world (Group Four).

Foundational to this tension is the difference in the perception of the persons for whom the job is being undertaken (that is, the community or the company/government) and a cultural clash as to how judgement would be made about the adequacy of performance. The tension pivots on the concepts of responsibility, authority and accountability, but to whom and for what?

The nurses are clear that they are members of a hospital that has for generations both belonged to and served a defined community, a community in which many of the staff live and fulfill a
number of other community roles apart from the provision of a nursing service. The managers are equally clear, as evidenced by the above quote, that they are running a business-like enterprise that must meet allocated contracts within allocated budgets. The RHA is, supposedly, the point of connection linking what the company is contracted for with what the community needs. Unfortunately, at the time of the study, the RHA had not been able to work out what the community needed or how to cost it. The default position was that the CHE was to be re-contracted for the services that they had provided the year before, as the RHA could not come up with an alternate mechanism for having an operational contract for the next financial year.

Geoffrey Hunt (1994) in his article “Nursing accountability – the broken circle” provides us with a helpful framing here. Hunt points out that a fundamental problem for nursing is that we believe we are accountable ‘downwards’ to the patient and community whilst in terms of our continued employment we are in fact accountable upwards to management, who are in turn accountable upwards to boards and hence to government agencies and to government. What is missing in this process and why, according to Hunt, the circle is broken is that the management, health departments or governments are not closing the circle with their direct accountability back to the community. The ballot box is far too blunt an instrument of accountability for defining and agreeing healthcare needs and service provision.

The radical problem of accountability is how to make health care, and thus nursing, publicly accountable, accountable to sick and injured people, the aged, mothers, disabled people, young people with HIV, children and so on (Hunt, 1994,133, original emphasis).

The measures by which the ‘work’ of the company is judged reflect the management criteria for accountability but primary among these is whether or not the company has kept within budget and how the patients felt about car parking facilities, as indicated in Chapter Four when discussing the CCMAU indicators. A community determined set of indicators of success in
meeting community health needs would look very different from those of CCMAU. Dr George Salmond, the Director General of Health at the beginning of the reforms, who resigned as a matter of principle as their direction became clear, said in 1997:

The reforms have tried to turn healthcare into a commodified business, but have run up against people who actually give things that you can’t demand of them. What we have got to do is run a system that mobilises from the community what the community will give. You’ve got to do it with your health community and in a social democratic way (Salmond, 1997, 21).

Hunt suggests that nursing’s accountability to the public is, in reality, only able to function as an instrument of an organisation. Within the organisation the nurses’ behaviour is constrained by policy and procedure to which sanctions are attached. Here we have echoes of the work in Tension One on emotional labour and the constraints on the freedom of nurses to be moral. Each of these tensions has at its heart a moral ideal of nursing in contradiction to the ideology of the “company” and therefore its instruments, the managers. Important here, however, is an appreciation that there are flaws in the systems that engage ideological constructs to shape human behaviour. Managers, by virtue of their jobs, are focused on things such as budgets that constrain nurses’ behaviour. This does not preclude them from believing they are operating in the patient’s interest, albeit at a more abstract level. This was poignantly expressed by a manager in Group Three when the nurses had been occupying the moral high ground for some time:

There seems to be a perception here at times that management don’t actually care about the patient and I can assure you to one hundred percent that the reason the managers are working in the place is that we have concern for patients as well. A lot of managers are extremely interested in a patient’s outcome as much as anything else, as much as their interest in financial outcomes (Manager, Group Three).

The managers perceive themselves to be equally ethically guided but by an ethic whose foundation is utilitarianism – the greatest good for the greatest number – as opposed to the nurses focus on the individual. The nature of the nurses accountability to the patient is moulded by the
political, economic and administrative form which the organisation takes and this in turn is
dictated, in this instance, by government legislation and policy, not by ‘nasty’ managers who do
not care.

It also is not that management is unaware of the emotional cost of the situation on the nurses as
was so well expressed in the interview with the manager who said of nursing:

Sad for nurses at the moment I think there is an emotional awareness and a
kind of spiritual awareness that something terribly wrong is on but they can’t
get hold of it ....So what state of mind some of them must go home at the end of
the shift in. God only knows.

The tightness of the reign of government over the CHE management was poignantly captured in a
cartoon of the day by Garrick Tremain in which a CHE boss is sacked over his demonstrated
interest in patient wellbeing. (See Figure 7.1). When I used this cartoon in a speech at R.H.
shortly after the action research group meetings concluded, the CEO requested a copy saying that
he identified with the cartoon. Four days later he resigned. He was quoted in the press two years
later at which time he said of the reform agenda:

Trying to apply the market model to health was like pushing water uphill with a
rake. It doesn’t work.... Normal commercial incentives were inverted with extra
work producing not a profit but a loss.... I saw the job as an opportunity to meld
the best of the public and private sectors’ philosophies but ended up with the
worst of both (XX, 1997, 11).

The professional and business cultures not only have a different values base but have their own
language systems. The use of language often clouded rather than clarified relationships and
communication. In speaking of accountability Hunt says:

It appears that here (accountability) is a concept serving an ideological function,
one which papers over the deep conflicts of interest.....In a reversal of the story
about blindfolded people feeling an elephant, all of whom come up with
different ideas about the object before them, here everyone thinks they have an
elephant when in reality they are really feeling quite different animals (Hunt,
1994, 131).
I was top man in the CHE. One day a patient said hello to me. Without even thinking I said "how are you?" dismissed!... obsessive concern for patient's welfare!!

Figure 7.1

"I was top man in the CHE"
Cartoon by Garrick Tremain
Dunedin, New Zealand
Reproduced with permission.
To Hunt's misleading "animal" "accountability", I would suggest we might add "best practice" "responsibility", "choice", "the individual", "autonomy", "freedom", "quality assurance" and "adequate staffing". Each of these terms had been used in the research, heavily laden with unshared meaning between nurses and managers. This was exemplified when in discussing staffing levels the senior nurse said:

Senior nurse: I felt the frustration by the end of the duty that this has been dictated to by admitting all these patients that the nurses have to look after and do the best for, probably not the best quality care you want to give but you just have to try to get them a bed and comfortable and safe. It's the most unsatisfying type of nursing but you are compelled to do it. Probably 50% of your working day or more is to do with staffing levels.

Researcher: Staffing for what, what are you staffing for when you say staffing levels? Staffing for safety or are you staffing for patient care for best practice?

Staff nurse: For safety
Senior nurse: Doesn't that make talk of best practice a lot of mumbo jumbo, because best practice doesn't just operate on the morning shift.

Lack of clarity in communication only served to exacerbate the tension between nurses and managers. Managers constantly asked nurses to explain nursing and when the nurses attempted to do this the managers had little background from which to make sense of the complexity the nurse was attempting to express. Throughout the research the nurses used metaphorical language when attempting to describe their practice dilemmas. We have seen many examples of this throughout the recordings of their conversations. For example: "So much of what we see is a square peg and so much of what the RHA is giving us is for round holes"; "The pastry left is the linking bit, nursing is the linking bit"; "The senior nurses were like fence posts, I suppose - the solid bits always there to refer to"; "You've got the completely wrong measurement. You're using a crescent to tighten a screw"; "The grass is always greener. I think maybe its all artificial turf" and "Can I answer that with a story?" The nurses used stories for clarity but the managers heard this only as an inability to succinctly describe their practice. Interestingly, Eisner (1991)
provides us with a clue to understanding this phenomenon that is not so derogatory about nurses’ use of storytelling and metaphorical language.

What is ironic is that in the professional socialization of educational researchers, the use of metaphor is regarded as a sign of imprecision, yet, for making public the ineffable, nothing is more precise than the artistic use of language. Metaphoric precision is the central vehicle for revealing the qualitative aspects of life (Eisner, 1991, 227).

Nurses are intimately associated with the ineffable in healthcare, in the qualitative aspects of life.

The nurses, in turn, were equally uncomfortable with the language of the managers:

Senior nurse: Some of the language is very fashionable, some of it is empty, some of it is politically correct and some of it has the power to accurately reflect, but it can also, in different contexts, be used as a petticoat on the hard-nosed cost effectiveness agendas.

Becoming multilingual and understanding the contextual appropriateness of different language forms is a challenge for nursing to which we will return in Chapter Eight. Hunt (1994) speaks also of lateral accountability as professional self-regulation but one may pose the question: ‘in what way does this lateral accountability gain expression in a context of managing care in an environment in which nursing control over the caring environment has largely been removed?’

Patient allocation described earlier as the remaining remnant of primary nursing disguises nurses lateral accountability by removing any mechanism for nurses observing each other’s practice and learning from each other. It creates a dangerous and isolated pattern of practice open to risk as nurses are allocated more and more patients to care for independently and without reference to more senior colleagues. With the removal of the charge nurse and replacement, in this instance, with a CNS the lack of lateral accountability has been exacerbated. The CNS has so many other demands on her time she is no longer expected to have oversight of all patients in the ward, thus the protective ‘holding’ of the group of patients by senior professional is removed, the
opportunities for error increased and the opportunities for growth and professional development are removed.

Decentralisation of responsibility and centralisation of authority have combined to leave nurses in an untenable moral position as indicated in the exposition of constrained moral agency in Tension One. The issue of the balancing of authority and responsibility is a critical one in easing the tension of the nurse. The business-like management of health care has resulted in the manager retaining the authority as it is inexorably linked to budget in the contractual system but responsibility moves right down the line to the “point of service” with the nurse in her interaction with the patient. This separation creates a situation ripe for rule-breaking as it places the moral dilemma with the nurse and the power to ameliorate that moral dilemma with someone else, in this study, the resource or general manager.

Senior nurse:  *There are all sorts of things that I agonise over like you know when Mrs XX who’s on the sickness benefit comes to have her pilonidal sinus dressed she can’t afford to go to the chemist to buy the dressing so you give her a few pads because otherwise she’s going to get the wound infected - you’ve seen it all before and all those little things that as nurses you do, even though you know you don’t want to do it, some of us are stronger than others, the district nurses - all the dilemmas that they have - they’re not going to get paid for going in to see this lady because they can only go in once a week - but knowing the need to go in - so somehow they manipulate the books so that they can get in another visit by adding on 10 minutes to everybody else - all that sort of stuff....*

Manager:  *The more we camouflage that the system is not going to change ...*

Senior nurse:  *It’s the ethical dilemma that you have as a health professional.*

Hunt, I assume somewhat tongue in cheek, proposes a utopian solution:

take away power from the doctors and make them technical advisers to nurses, midwives and health visitors (in the way laboratory technicians have no power but only technical expertise); and take away the power of the managers, fundamentally decentralising and democratising the health service beyond anything we have unimagined so far, and making nurses responsive within small-scale health care set-ups to health care representatives of the community (Hunt, 1994, 145).
He does go on to provide constructive meantime suggestions for closing the circle of accountability and bringing the community voice into both the setting of the healthcare agenda and the determining of the criteria by which performance is judged. Nurses have two imperatives here. One is to engage the community and make audible the voice that demands community representation on area health boards and health service provision committees, and the second is to take control of the ward environment.

The hierarchical generic business model had been superimposed by legislative changes across New Zealand to all state-owned-enterprises and health was simply one of them. Healthcare managers were constrained by their external environment in the ways in which they were able to operate and in this tension it was the managers who were in the moral squeeze. This difficulty was drawn powerfully in Tension Two when the manager indicated that moving in any way from the government view or process would result in being sacked. Garrick Tremain’s cartoon (Figure 7.1) reinforces this. But perhaps the most poignant statement about the managerial philosophy is made by Michael Leunig in his cartoon appearing in “The Human Cost of Managerialism” (Rees, 1991). See Figure 7.2

**Tension Three - Conflicting philosophies of management and leadership.**

This tension again is a result of a difference in the basic philosophical positioning of the individual versus the relational and connected; but this time not the individual as in the individual patient, but rather the individual as an autonomous, independent being. It has strains of Gilligan’s (1982) critique of Kolberg’s (1981) work and juxtaposes the hierarchical model of relationship with the web of connectedness.
What profit a man
if he gain the whole
world but lose his
soul?...?

Well, we've done a few figures on that
and you might be pleasantly
surprised because it seems
that there is quite a profit
Quite a nice profit in fact...

and what would the
profit be like if you
lost, say, half your soul
and gained only
half the world?

Still very nice!
It's a huge audience - a huge market
and I'd like you to consider the following:
I know a man who has only
one sixteenth of his soul left
and he's perfectly happy -
perfectly happy!!

Figure 7.2

"A fairly typical discussion"
Cartoon by Michael Leunig
In "Rees, S. & Rodley, G (1995)
The Human Cost of Managerialism"
Reproduced with permission.
Brian Easton, New Zealand health economist in his landmark article “The rise of the generic manager” raises the point that:

There are a number of economic products and services whose characteristics are so different from the general run of commodities that they have typically been treated quite differently from those conventionally supplied by private enterprise indeed at could be argued that the raison d’être of the public service was that its ‘outputs’, to use the current jargon’ were so different from those of the market that they required different management styles (Easton, 1995, 41).

Easton names health services amongst these exceptions. Easton’s view was drowned out by the dominant treasury view of the late 1980’s in New Zealand where the desire to have public services, or “state-owned enterprises” as they became, was not differentiated between when the new management ethos took control.

From the beginning, the underlying premise was the health services were just like any other economic commodity and could be supplied in the same way, and ideally should be funded privately. In fact, the provision of health services is very different from the standard commodity, because the person who decides on the health care service to be provided is rarely the user (i.e. the patient) and frequently the provider (i.e. the doctor), while the funder is rarely either the user or provider but someone else (in the private sector the funder is usually the private insurer). Thus the main strengths of normal market transactions simply do not apply to the standard health service exchange (Easton, 1995, 43).

By 1997, this view had been ameliorated but by then efficiency and performance management had become part of the national bureaucratic culture. By January 1997 the headlines of the capital city newspaper read “Out with the new and in with the old” and the feature article began:

January 1997, and everything old is new again. The Government’s coalition agreement has come up with a model that looks remarkably like the public system before 1993. The four RHAs are to be collapsed into one; public hospitals will no longer be expected to make a profit; health funding will once again be based on population; closer links are to be forged between hospitals and community services and more emphasis will be placed on prevention and public health. Cooperation is the new keyword.
In the same article the Minister for Health is quoted as saying “Last time we lost a lot of institutional knowledge – we don’t want that to happen again” (English, 1997,11). His Associate Minister expanded on this saying: “Stability in the sector is critical” (Kirkton, 1997,11). The article then refers to an interview with one of the CHE CEOs:

Why, in the wake of the coalition agreement, could NZ first achieve in just a few weeks what health workers had failed to get despite protesting for three and a half years about inconsistent funding, inequitable access and poorer health? It shows the danger of political power in the health sector. I’m a much happier guy today because of it, but it could just as easily have been the kiss of death. If political power can produce such an effect so quickly and radically then the health sector is in real danger (Levy, 1997,11).

The business model has left a legacy of economic accountability and an expectation that all aspects of healthcare provision are or will be able to be costed and this includes nursing care. This challenge has been taken up by a number of nursing research groups and will be discussed further in the following chapter.

So if the management side of this tension was dictated by the political environment of the time, what of the nursing side of the commitment to involvement and engagement? Since the advent of the modern hospital, nurses have been the coordinators of care and communication. Nurses are the professional group who know the patient and their needs and orchestrate the care provided by other professional and service groups. Englehardt (1985) designated nurses the ‘people-in-between’ – between the patient and the physician. Englehardt sees this as a position of ambiguous rights and authority. Bishop and Scudder (1990, 1991) further developed Englehardt’s work adding to the ambiguous position of the nurse by placing the bureaucrat in the triangle with the patient and the physician and the nurse in-between. Whilst admittedly holding ambiguity and a potential to be ‘caught” as suggested by Englehardt and Bishop & Scudder, it also holds possibilities of connection.
The removal of the senior nursing positions by CHEs across the country and the restructuring either under business managers or leaving unclear accountability structures such as the one at R.H. have left a black hole in terms of both horizontal coordination of care and vertical and horizontal coordination of communication, both traditionally nursing functions. The vertical coordination of communication was typically the province of the principal nurse/director of nursing and the lateral coordinator of care at the ward level by the charge nurse or nurse unit manager. These positions were the strongest threads in the web of connection that permeated the hospitals; the nurses in this study missed them enormously and saw their lack as leading to fragmentation, poor communication, lack of professional development and little professional leadership.

Magnet hospitals, which are hospitals able to retain and attract nursing staff, have been the subject of study for over twenty years now and have characteristics that have withstood the changing healthcare environments over that time. This research is apposite to this tension as it provides an evidence-base to the nurses’ call for a model of leadership and management they named as shared governance.

The organisation of nursing in these magnet hospitals has demonstrated three distinct core features:

- Professional autonomy over practice
- Nursing control over the practice environment, and
- Effective communications between nurses, physicians, and administrators (Havens & Aiken, 1999, 16).
All hospitals receiving magnet recognition had nurses in senior executive positions and 86% of those hospitals demonstrated a model of shared governance (Porter-O’Grady, 2001). The senior nurses in this study indicated on several occasions their familiarity with the magnet hospitals’ research to that time. It was clear they had pressed the managers to consider models of shared governance as a means of establishing a collaborative vision and to provide a vehicle for leadership and professional development but this was not heard at the time.

Senior nurse:  I think leadership is something quite different (to management of people and budgets) and leadership is about holding a vision and being able to get other people to see it and to get towards that vision, move towards the vision by putting the processes or the structure to get there.... What’s happened lately is that they’ve retreated into “management without vision” and that’s what’s really affected everybody....When they retreat back into budgets they lose, they’ve lost it. They’ve lost the vision and I guess people do that when they’re in survival mode.

This survival mode was directly related to the political environment at the time. One of the managers, deeply aware of the destructive nature of the turmoil on clinical practice, was drawn to suggest the manager’s role should be one of providing protective space away from the turmoil so that the clinician could develop new modes of practice in spite of the political environment:

Manager:  Underneath this maelstrom cloud of political garbage that swells around health above us, somehow we have to plant some new seeds, driven by health professionals with a vision. It can take a ten-year journey to get there and it is going to be one hell of a journey and it may not work, but I don’t think there is any other reality. Because that maelstrom will keep coming down until underneath it you can build a new fabric.

Senior nurse:  We need to find out how far you can go pushing that a bit higher to get some breathing space so it doesn’t get quite so oppressive, without having it come down on top of us (Group Three).
Tension Four – Discordant expectations:

This tension represented the cumulative effect of the other tensions, culminating in a discordance of the unshared expectations of key stakeholders of the new healthcare environment. Claire Fagin (2001) in her influential paper “When care becomes a burden”, determined that the lack of accepted expectation about caregiving was one of the three major causes of the increasing sense of burden, the other two being the changing nature of hospitals and hospital reorganisation.

Nurse, physicians, patients and families have formed their expectations about care over many decades. Personal experiences, fictional depictions, and anecdotes from family and friends shape notions about care. The concepts care and nurse are both freighted with complex historical and emotional content. Seldom verbalized, this social legacy has contributed to public expectations about caregiving. That the nature of hospitalization has changed, that demographic changes have brought different emphases to the health care system, that financial pressures have led to restructured and reorganized systems, and that hospitals have had to alter their mission to suit these financial and demographic shifts – all these developments have been received with gloom and anxiety by patients and potential patients and with concern by nurses and physicians (Fagin, 2001, 12, original emphasis).

In the context of this study not only are the words of Fagin apposite, but superimposed upon these concerns for the patient, there is the added deliberate obfuscation of the government in New Zealand at the time. The government has since conceded it had no intention of clarifying the situation in relation to healthcare provision for the community. Lack of explanation about almost all aspects of the reform was part of the plan to so radically change the public service that, by the time public opinion gathered sufficient momentum, there would have been change so significant that the pendulum would never have been able to be swung back to its original position (Douglas, 1993).

Management was confused over what it could or should tell staff as was seen so clearly in Group One:
It becomes a real dilemma in terms of how you communicate that to others, and if you communicate it honestly, and one week you say one thing and the next week you say something else, the week after that you say something different again. All of what you have said has been the reality and that is the honesty of the situation, yet it is very easy to perceive that “shit, you’re the manager and you don’t know what the hell is going on (Group One).

The level of confusion and discord permeated every layer of society in New Zealand in the mid 1990s. This was not restricted to the healthcare environment but it did deeply affect health and therefore all sections of the community, as healthcare is a social service that touches every member of society.

For this chapter the last word will be from Brian Easton, ever the vocal public critic of these health reforms:

The turmoil of reform, without any evident gains, has meant that those who benefit from the agencies have suffered, as has the public purse and the future. Undoubtedly the health of some New Zealanders has suffered. Yet less than might have been expected. For despite the insecurity and demoralisation the reforms caused staff, they have continued to maintain their high standards of performance in health care. Fortunately for the patients, the culture of the health professionals has triumphed, despite the attempts by managerialism to override it (Easton, 1995, 47).

In the following chapter we will explore the consequences for nursing of having unpacked some of these tensions. We will look at the necessary changes in practice, the understanding of practice and the situation in which practice takes place (Carr & Kemmis, 1986) that have been uncovered so that nursing will never again be as unprepared for radical changes in its external environment.
CHAPTER EIGHT

Easing the Tension: Lessons learned.

Taking heed and taking heart

We shall not cease from exploration
And the end of all our exploring
Will be to arrive at where we started
And know the place for the first time

T.S. Eliot
CHAPTER EIGHT

Having explored the issues creating the tensions for the nurses in Chapter Seven, we are now in a position to use these insights to illuminate a way of improving the practice of nursing, our understanding of that practice and the situation or context in which practice takes place, so that nursing will be better prepared for radical environmental changes in the future.

From the exploration of tension one: managing the patients vs managing the healthcare business, we learned of the critical nature of nurses’ control over the environment of practice. This control enables appropriate staffing decisions to be made within models of care delivery that are adequately resourced. We saw the need for nurses to first nurse themselves and each other in order for them to have the capacity to nurse others without physical or emotional exhaustion. We saw the need for a clinical career path for nurses which allows clinical expertise to remain aligned with patient care delivery, not to be lost or diluted simply by having to leave the bedside for career progression in management, education or by leaving nursing altogether. Above all we saw the crucial need for nursing to accept as its responsibility participation in the politics of healthcare as a necessary expression of an ethic of care.

Examination of tension two: service to the community vs working for the company, exposed the importance of nurses lobbying within and with the community for community voice in healthcare decision-making and service provision. We saw also the importance of nurses not only having their own professional language but being skilled in multiple “languages” in order to communicate effectively about healthcare with different audiences.
Exploration of tension three: conflicting philosophies of management and leadership showed the importance of a connected or shared governance model for health service delivery. This model includes the presence of nurses as both coordinators of care and coordinators of communication in order that resource allocation decisions are informed by patient care requirements.

Unpacking tension four: discordant expectations of health service provision emphasised the critical nature of engagement of all contributors in healthcare such that expectations are formulated in an inclusive way and rationing of care provision is not done by default or stealth but by informed community debate.

In this the final chapter of the thesis, these issues will be discussed with reference to the work which has been done to improve patient care and our understanding of healthcare practice since the time of the action component of the research in 1995. This will enable us to draw on the widest available resources to formulate strategies for the profession to move forward, minimising the possibility of nursing being made so vulnerable again in a future time. The framework that will be used is that which has pervaded this work, the expanding circles of concern seen in Chapter Five in Figures 5.1- 5.4. This framework is consistent with the Carr and Kemmis (1986) action research framework, again referred to frequently. The patient is at the centre of the day-to-day practice, the immediate environment of which is mediated by our understanding of practice. The management of the hospital and healthcare environment governs the context or situation of practice. Because understanding of practice enables potential change to practice this understanding will be explored first followed by practice and finally the context or situation of practice.
The Understanding of Practice:

Implications from research:

The practice of nursing and its relationship to patient outcomes was largely unexplored in 1995 at the time this research began. When called upon to justify the need for an all registered nurse workforce and for particular staffing patterns the nurses of R.H. had a level of practice wisdom but little in the way of evidence on which to justify their requirements. Staffing for the troughs and managing the peaks on casual staffing was not a surprising business decision for a manager from an industrial business model. When orders are placed in advance, ‘just in time’ gearing up for increased demand is sensible and efficient business practice. Nurses were unequipped to convince managers of the inappropriate nature of such resource decisions within acute care hospitals and the dangers of such decisions for patient safety.

As indicated earlier the senior nurses in the study had demonstrated their knowledge of the research into magnet hospitals, those hospitals that retain their staff and have high staff and patient satisfaction. The nurses knew the characteristics of magnet hospitals included having nurses in the organisation at senior executive level, autonomy in clinical decision-making related to nursing, decentralised decision-making at ward/unit level and an organisational culture of openness and collegiality (Kramer & Schmalenberg, 1988a&b, 2003 a,b&c; Kramer, 1990). What the nurses at R.H. did not have at the time was an evidence-base from which to move these characteristics away from self-interest and locate them with improvements in patient outcomes. The nurse ‘knew’ the staffing levels impacted on patient safety but were unable to prove it.

Gradually this evidentiary link has been established, showing increased registered nurse numbers relative to patient numbers influences the incidence of nosocomial infections, pressure sores,
adverse incidents and provides better patient outcomes (Blegen, Goode & Reed, 1998; Blegen & Vaughan, 1998; Kovner & Gergen, 1998).

A further message that was unheard at the time of the study was that these issues of workload and workforce were not local concerns voiced by isolated nurses, or even national concerns, but international issues of significance to the safety and quality of patient care provision. Aiken, Clare, Sloane, Sochalski, Busse et al (2001) published a five country study in the international journal ‘Health Affairs’ in 2001 in which they showed that whilst the majority of nurses believed high quality care was being provided by clinically competent staff, only 30-40% of nurses reported that there were adequate numbers of registered nurses to ‘get the work done’ and provide quality care. In the United States and Canadian components of Aiken’s, 30% of nurses reported necessary nursing tasks associated with patient hygiene and comfort needs were being left undone due to nursing overload. The five countries involved were the United States, Canada, England, Scotland and Germany, countries with which New Zealand would readily compare itself in relation to healthcare.

This research report was followed in 2002 by an article by Aiken, Clarke, Sloane, Sochalski & Silber published in the Journal of the American Medical Association (JAMA) entitled “Hospital staffing and patient mortality, nurse burnout and job dissatisfaction”. Here the researchers demonstrated, in a study of over 10,000 nurses, that each additional patient allocated to a nurse was associated with a 7% increase in the likelihood of the patient dying within 30 days of admission and a 7% increase in the odds of failure-to-rescue should they encounter an adverse event. For the nurse, each extra patient was associated with a 23% increase in the odds of burnout and a 15% increase in the odds of job dissatisfaction.
Such robust research undertaken in multiple sites and published outside the discipline is fundamental to being able to link nursing concerns to patient safety and hence to the agendas of decision-makers. Aiken and her colleagues have taken their early work on magnet hospitals and developed and refined it over a nearly twenty year period in a way that has extended it well beyond an issue of interest only to nurses, spoken about only at nursing conferences and published only in nursing journals. They have linked the issues of interest to nurses to issues of interest to the public, and reported them in health policy and medical journals thereby extending both their relevance and reach. This reframing of issues of concern to nurses away from self-interest and attaching them to the interests of others is a key to health policy success for nurses.

The importance of reframing was made cogently by Donna Diers (2002a). She suggests that, in “When care becomes a burden”, Fagin (2001) reframes the nursing shortage as “diminishing access to adequate nursing” thus making it an issue of the public’s right to nursing care. Linda O’Brien-Pallas’ work in Canada on workforce Diers sees as a reframing of the “workforce as warm bodies or interchangeable worker cogs” to a human resources issue of a healthy workplace (Baumann, O’Brien-Pallas, Armstrong-Strassen et al, 2001). The research team achieves this by looking at overtime and sick-leave increases and aligning them to the increases in nursing workload. As a human resource issue it attracts a different audience of concern.

Whilst in some areas, such as California and Victoria in Australia, staffing ratios have been mandated through industrial agreements, other professional bodies are cautious of this one-size-fits-all approach and are awaiting the outcome of further research from Canada, Australia and New Zealand. This international research led by Linda O’Brien-Pallas employs a model that
takes cognisance of the messiness of the context of practice and takes into account characteristics of the nursing staff, the medical conditions of patients and their severity, patient nursing complexity and the environmental complexity (O’Brien-Pallas, Irvine, Peereboom & Murray, 1997). The outcomes of this research will provide evidence-based, quality-adjusted ranges for nursing staffing standards and will thereby inform nursing costing policy development for ongoing monitoring of nursing care requirements in a more refined, sophisticated and sensitive manner than an industrially driven static minimum ratio (Shullanberger, 2000). This research has the potential to provide a tool for accurate costing of nursing care. No longer will we need to use ‘a crescent to tighten a screw’ as our senior nurse put it.

A further distinct body of work, this time developed within medicine but influenced by the airline industry, has coalesced with the nursing research on staffing. This research on medical error or adverse events at Harvard and in Sydney has studied the incidence of death and disability suffered by patients as a result of being in hospital (Brennan, Leape, Laird, Herbert, Localio et al, 1991; Leape, Brennan, Laird, Lawthers, Localio et al, 1991; Wilson, Runciman, Gibberd, Harrison, Newby & Hamilton, 1995; Wilson, Harrison, Gibberd & Hamilton, 1999). The results were of such cause for alarm that considerable further work has been generated on how we might minimise the systems components of these adverse events. The studies have shown that the single most important factor influencing the success rate of saving patients experiencing an adverse event is the level of registered nurse staffing (Silber, Rosenberg & Ross, 1995 in Fagin, 2001, 10).

Research undertaken by Donna Diers and a nurse manager of a ward at Yale-New Haven hospital which had been seen as the worst run ward (over budget, high levels of sick leave and poor
patient satisfaction), determined that the breadth of spread of Diagnosis Related Groups (DRGs)
in any ward influences the quality of the care given and the ability to run the ward efficiently
(Diers & Potter, 1997). By limiting the casemix the ward was rapidly turned into an example of
efficiency and satisfaction. The practice of hospital managers of focusing on bed management
rather than patient management has not only lessened the job satisfaction of nurses who are
nursing not to their expertise but to the lowest common denominator of care, but it is producing a
less efficient and more expensive system. When patients are grouped according to the primary
reason for their hospitalisation and cared for by staff highly educated in that specialty, the care is
safer and more cost effective, not to say more satisfying for patient and nurse.

We are building a body of evidence that enables nurses to argue with evidence and anecdote, a
very different position to the position for nursing in 1995. But more needs to be done. The
number of nurses with research training in New Zealand is still small and, whilst international
studies are valuable, local replication studies are important to persuasive political argument. Of
the nurses with research training too few are expert in economic analysis or quantitative research
generally. And the breadth of our nursing concern necessitates research not only into the lived
experience of the patient or the effects of change but also causal and correlational studies that
provide answers to the sort of questions policy makers inevitably ask.

Aside from the understanding of practice generated through research, understanding is influenced
by the educational preparation of practitioners.
Educational implications:

Undergraduate nursing education programmes, in their desire to redress the imbalance of the task focused model of care, could themselves be seen to have been guilty of some pendulum swinging. The emphasis on the nurse-patient relationship and the responsibility of the nurse for meeting all the needs of the patient had been designed to prepare the new graduate for an environment of primary nursing. The clinical environment however had been stripped of the necessary supports and left with patient allocation as the only remnant of primary nursing. The newly graduated nurse under these circumstances was left with an intolerable moral burden, a lack of framework from which to reconceptualise care provision, and a lack of agency. Education programmes could be seen to have, in fact, set up the circumstance which has left the nurse in Chiarella’s (2003) “ethos of individual responsibility” and “practice zone of isolation and alienation.”

I am not suggesting here a reversion to task teaching, but rather a focus on the patient and their care needs in whatever way this is best achieved in any given circumstance. I am suggesting providing nurses with cognitive frameworks which enable them to adapt in meaningful ways to differing contexts. This speaks to the need to educate nursing students about an ethic of care that has as a fundamental component political understanding and responsibility for action.

The concept of the healthcare team has virtually disappeared from many nursing curricula; here another pendulum swing is seen as a response to having had such medically dominated curricula in the past. As educators we are guilty of throwing some important babies out with unimportant bathwater. Individualised models of care delivery have blinded many practitioners to the important and differing contributions each healthcare practitioner can make to a patient’s care.
Not only is this an important oversight in terms of the development of the nurses’ ability to coordinate care but it reduces the “caring-well” of connected relationships from which the nurse can draw strength.

Nurses need to be assisted to reframe their understanding of the expression of the nurse-patient relationship and nursing practice in the contemporary healthcare system and to see themselves as caring and connected knowledge workers who bring humanity to an otherwise often dehumanising technically focused illness–cure system. Surrounding this point of technical intervention is a system of other sites of care such as post-acute home based care, nurse-led step down units and community health care facilities. The nurses’ roles here are manifold and different to those of even five to ten years ago. This has been elegantly captured by Fagin (2001) in “When care becomes a burden”:

It is unrealistic, however, to expect to be able to develop the kind of relationship both nurse and patients desire when a typical patient is hospitalized for 24 hours or less. Such brief hospitalizations inevitably lead to disappointment and frustration if expectations remain fixed at levels common as recently as five or ten years ago. Rather, in such situations one should expect an expert nurse, one who provides superb care during the intense time of hospitalization and has the knowledge and connections to coordinate care among hospital nursing staff, the community nursing group, and the family. Ideally, integrated health care systems would look at the entire trajectory of patients’ needs – from prevention, to care during acute illness, to rehabilitation and convalescence, and on to wellness, chronicity or death. Currently however, many patients find themselves being discharged without meaningful planning for transition care (Fagin, 2001, 12-13).

The challenge for educational programs is to equip nurses to move into and out of these different roles in healthcare and the different relationships they each necessitate. This is a challenge for both undergraduate and postgraduate nursing programmes.
The Practice of Nursing:

Fagin (2001) claims patients and their families have expectations about caregiving that have deep and extensive roots, as seen in Chapter Seven. Nurses have equally long roots in their understanding of their practice and their relationships with patients. But we have a context both within this study and within nursing internationally, in which few of these expectations are being realised.

The focus on the nurse-patient relationship, to the virtual exclusion of other relationships, has left nurses in a position of vulnerability. If nurses are to be able to provide care for patients they must have opportunities to refill their "caring-well" with more equal relationships, as suggested by Hanaford (1994), they must build and develop sustaining relationships with other nurses and other members of the health team. One consequence of the confluence of hospital restructure, with nurses one-way gaze to the patient, has been the diminution in the strength of the web of connection which used to be the hallmark of a ward/hospital environment. When the charge nurse "held" the ward environment metaphorically in her hands, patients and their families felt cared for, felt someone knew them and their needs, that there was a security blanket or 'fence posts', as they were referred to earlier by a manager. The loss of this position or the swamping of it by administrative tasks to the point where knowing the patients has become impossible, has been the near fatal flaw in the restructured systems' ability to provide safe patient care.

Norrish and Rundall (2001) suggest there are three key characteristics that define the nature of nursing work in any setting: work roles, workload and control over work. When in the late 1970s and 1980s nurses moved away from the allocation of tasks to a model of "total patient care", as
indicated in Chapter Seven, this was a move towards an all registered nurse workforce. This move, facilitated by the transfer of nursing education out of hospitals, provided the possibility of the introduction of primary nursing as the model of care (Manthey, 1980). As we have seen primary nursing is the assignment of decision-making about patient care throughout their hospitalisation to one nurse, assisted by associate nurses. As also indicated earlier, this model is predicated on having a stable staff who know and trust each other, and having a person with oversight of the environment who is also the pivotal point of communication. The role of the head nurse / charge nurse or nurse unit manager, as the position is variously known, was for Manthey (1980) one of the four major design elements of primary nursing. In this role the nurse manager hired staff, allocated resources, evaluated performance, set practice standards and held staff accountable to those standards of care, while the patient care decision remained with the primary nurse (Norrish & Rundall, 2001). Indeed, a fundamental characteristic of a magnet hospital was the opportunity for nurses to consult with a nurse manager on daily patient care issues.

The reality for R.H. and for many hospitals in New Zealand and internationally was somewhat different. What remained the ideal form became an unsupported system of patient allocation. More patients were allocated to any one nurse than they could provide adequate care for and yet these were patients with whom, because of this new system, the nurse had a closer relationship and so higher expectations of her own ability to meet the needs of these patients. Work role, therefore, was impacted upon strongly by workload and the increase in workload caused by increase in both patient numbers and acuity levels became not only not an ideal form but a dangerous one, and one unsatisfying to either nurse or patient.
At R.H. the increase in workload was superimposed on the removal of the charge nurse and the failure to appoint a principal nurse or director of nursing when R.H. was disamalgamated from the previous area health board. Workload therefore impacted on and in turn was impacted on by loss of control over nursing work. The senior nurse in the organisation had responsibilities that were largely invisible to those outside nursing. Communication channels, coordination of policy development, career and professional development were not seen by business managers as "adding value" and yet they were the strongest structural threads in the web of hospital connection. Control over nursing work by nurses is therefore the fundamental building block for safe patient care provision, as this, in turn, structures work load and work role.

Where primary nursing may not be a model of preference or be able to be supported, shared governance allows for new models of care to be collaboratively established that take heed of the need for support for the nurse in order that she may support the patient. This support comes from a redeveloped sense of team and of knowing not only the patient but each other within the health team.

It was not surprising to find nurses at R.H. calling for a model of shared governance, under which nursing practice is controlled by nursing staff. Under a shared governance model committees and councils structurally ensure a nursing participation and voice in planning and decision-making about resource allocation. There is a forum for negotiation between the competing values of business and health professionals in meeting the organisational goals (Norrish & Rundall, 2001; Porter-O’Grady, 1994). The link between shared governance and magnet hospital status has now been made. This together with the link between magnet status and patient outcomes provides an evidentiary chain linking a model of shared governance to improved patient outcomes and
provides strength to an argument that otherwise is deemed self-interest and time and money consuming. This chain of evidence has provided a much needed basis for nurses to influence the structuring of the practice environment in a way that enables neither caring practices nor patient safety to be compromised. Achieving this will in itself improve the job satisfaction and lessen the moral burden for nurses. The reinstatement of senior nurse positions at executive level provides the important voice and communication link through which nurses are able to make their cumulative story known and exert political weight.

The Situation of Practice:

Jean Watson reminded us in Chapter Seven that when morality reaches the public its expression is politics and when morality reaches the “allocation of health resources, division of professional labor, and control of practice rights, it’s called health policy” (Watson, 1990, 64). Engagement in health policy is the necessary and appropriate outward focus that balances the inward focus of the nurse-patient relationship within a feminist ethic of care. Chopoorian as long ago as 1986 challenged nurses in this regard by reminding us:

Nursing practitioners continually confront the human responses to the underlying social dynamics of poverty, unemployment, undernutrition, isolation, and alienation precipitated through the structures of society (Chopoorian, 1986, 40-41).

As nurses we claim patient advocacy as a fundamental moral responsibility and yet are silent in the very forums where this advocacy is most needed, where resources are allocated and social structures determined. There are two aspects to redressing this situation, the need for nurses to become multilingual in the language of their practice and the language of business, politics and policy development; and the need to develop an understanding of health policy, its formation, implementation and evaluation.
Developing our ability to speak:

Despite many years of encouraging nurses to speak publicly about what they know of healthcare, Buress and Gordon have recently said:

Over the last decade we have come to believe that there is a profound ambivalence in nursing about whether it is even advisable to be more visible, more vocal, and to have a larger role on the public stage (Buress & Gordon, 2000, 5).

I believe this confusion comes from a confusion within nursing about who should say what and to whom. Nurses who work at the bedside have been so indelibly imprinted with notions of patient confidentiality that they have difficulty in separating out the appropriately public cumulative story from the private individual story. They are confused also about language. Nursing, as with most professional groups, has its own language, often metaphorical, always involving story and always convoluted and full of detail. Whilst, as Eisner (1991) said, this is appropriate for describing the ineffable, qualitative aspects of life, it remains incoherent to most inside healthcare but outside nursing. When speaking within management or policy circles nurses must be conversant with the language of those other disciplines (White, 2002). We must be able to speak succinctly and back up our assertions with facts and figures, as these are the points of entry used within business and politics to gain access into conversations. Ironically, these conversations often then take on story and anecdote as their main form of interaction. The gatekeeping function of the facts and figures is a lesson to be learned if we are the ones who seek entry into the conversation (White, 2002).

It is vital for nursing to separate that which should stay within nursing, the language shared at our professional meetings, our secret nurses’ business, from that which is public business and appropriate for conversations with management and bureaucrats; and that which is the public’s business which should be conveyed meaningfully to the general public. Each of these forms of
communication has its own style for effective transmission of meaning and must be learned by those best placed professionally to use them on behalf of other nurses and patients.

**Developing our understanding of health policy:**

Nurses have not been seen as having a contribution to make to policy in relation to health structures, systems, outcomes or quality and safety (Brown, 1996; Buerhaus, 1992; Hughes, 2001, 2003; Stimpson & Hanley, 1991). And yet we are intimately affected by and central to each of these concerns.

For nurses, as we have seen, health policy engagement is a responsibility if we are to suggest we are advocates for the patient. Education about health policy is therefore essential. A difficulty arises, however, when one explores the usual health policy texts and discovers very many policy frameworks, each linear and logical, but completely unrealistic to anyone who has worked in the reality of the health system "messy swamp" rather than the high hard ground of academic authorship (Schon, 1995). A model which does hold value for nurses is that of Kingdon’s (1995) model, based on Cohen, March and Olsen’s (1972) “garbage can model”. Rather than taking a linear rational approach, both Kingdon and the ‘garbage can model’ make room for the serendipity that is the political process. Kingdon suggests there are three streams in policy making: the Problem Stream where issues need to become defined as problems before they enter agendas; the Policy Stream, where the ideas float around “in search of a problem” (Hanley, 2002, 58); and the Political Stream, which includes the factors in the political environment that influence the policy agenda, such as electoral cycles and budgets. These streams are seen as floating along until a focusing event brings at least two streams together.
Streams come together at critical times. A problem is recognised, a solution is available, the political climate makes the time right for change, and the constraints do not prohibit action (Kingdon, 1995, 20).

This is a model nurses can understand. The ambiguity of it makes innate sense to them. Nurses can learn to influence the coming together of these streams by focusing healthcare messiness into definable problems in search of a solution. They can have the research evidence ready to provide solutions when problems are defined, and they can use their knowledge and their numbers to influence the political climate. Sally Cohen and her colleagues have provided nurses with a helpful framework for understanding the stages of political development which underpin policy influence (Cohen, Mason, Kovner, Leavitt, Pulcini & Sochalski, 1996). This map details stages of development from ‘buy-in” through “self-interest”, to “political sophistication” and finally to “leading the way”. Against each of these stages of development Cohen et al explicate the characteristics of “the nature of action”, “language”, “coalition building” and “nurses as policy shapers”. This framework shows clearly that in 1995 nursing in New Zealand had been pushed by circumstance to a position that, if on this map at all, was at best at stage two “self-interest”. In stage two they were seen to be reactive to nursing issues rather than proactive in both nursing and other health issues; to use nursing jargon rather than the “rhetoric common to health policy deliberations”; to form coalitions only within nursing organisations; and to shape policy only within directly nursing related issues, not within broader health concerns (Cohen et al, 1996, 260).

Frances Hughes (2003), chief nurse of New Zealand, in her recent doctoral work further refines Cohen’s model using the experience of nurses in New Zealand as the focus of her analysis. Hughes extends Cohen’s model as she sees it to be missing a characteristic against which stages of development can be described. That characteristic is one of “building relationships”. The New
Zealand experience had shown that relationship building, subsumed by Cohen et al within coalition building, is indeed a separate characteristic of political development. The development of interpersonal relationships underpins and reinforces both within and between group relationships and it is the group relationships that are characteristic of coalition building. After the disintegration of relationships through these reforms, relationship building was paramount for nursing.

George Salmond, ex director-general of health and already referred to several times in this work, said of health policy for New Zealand:

Central to good policymaking is acknowledgement that health is part of a complex social system, the pieces of which are not only interconnected but also interdependent. Whatever the merits of particular institutional configurations, in the age ahead individual and group behaviour and trusting relationships will be more important than structure and regulation, nationally as well as within organisations. That is, we believe the principal lessons from the past fifty years of health policy making (Salmond & Martin, 2001, 49-50).

The study of health policy was introduced at the Victoria University department of nursing and midwifery as a core subject of the masters programme in 1995 and has, since 1997, been introduced to the professional doctorate at the University of Technology, Sydney both as a subject of study and as a compulsory theme to be given expression within the doctoral work itself (White, 1999). Apart from specific subjects within graduate courses there remain no structured policy schools or forums for senior nurses to share ideas and develop their skills in either New Zealand or Australia. Frances Hughes, Donna Diers and I have a policy school planned for later in 2004.

New Zealand nursing has developed its understanding of the political process and could currently be seen as operating in at least Cohen et al’s third stage of development: proactive on nursing and
some other health issues, using language appropriate to the forum of the conversation, forming coalitions among nursing groups and participating with broader healthcare groups; and enjoying success in having nurses appointed to some health policy related positions. But, as Cohen points out, these are slippery positionings and one can easily fall back to less sophisticated levels. There is also still some way to go before reaching stage four and "leading the way".

This exploration and the voices of the nurses from 1995 have helped guide us to a position of knowing what needs to be in place for nurses to be able to appropriately care for patients. The 1995 experience of the commodification of caring has brought to light the imperatives for nurses for the future: to work with patients and families, not only with engagement but with agency; to work with each other as teachers and caring role models with appreciation and a collegial spirit of generosity; to work in systems designed to provide quality care and communication, thereby affording nurses a central and rightful place in healthcare; and to work with governments and opinion-makers persuasively with a rich blend of evidence and story.
AFTERWORD

Coming Full Circle

In Good Heart
"Journey of the Heart"
Painting on woven flax
By Suzie Pennington
New Zealand
Private collection
Jill White
AFTERWORD

In coming full circle I felt the thesis to be incomplete without affording you, the reader, the opportunity to gain an update on my thinking about the methodology in hindsight, the context, the CHE R.H. and the nursing profession in New Zealand today. So briefly:

The methodology:

Throughout this work I have taken pains to keep authentic the chronology of influences on my thinking. I believe I have laid a thick and rich audit trail so that you, the reader, have known not only what I did at any time but why and how I did it. I believe I have remained true to the philosophical underpinnings spelled out in Chapter Two so that you have been engaged in the journey of discovery and interpretation and heard the voices of those involved. The feminist lens has played an important role not only in the application of method but in the analysis and the interpretation, particularly in the critique of the ethic of care. I have delighted in the Gadamerian hermeneutics, or perhaps found it an excuse for hanging on to an unfolding story, as I journeyed into and out of professional conversations. Breaking the hermeneutic circle at this time has been important, not only because it was past time to put the story down, but also because of the growing body of nursing and healthcare literature that could now be blended with the learning from this study to provide a path forward for nursing, one which was not until recently available.

The action research component remains for me the treasure at the centre of the study. It was a privilege to share those conversations and they stay with me vividly. I believe the use of the feminist group process of Wheeler and Chinn, as a structuring device to enter into the group work and to engage the participants, is a significant contribution of this study. Action research used with this caring and regardful approach is a safe and appropriate research approach to use with
busy clinicians who do not know or trust each other as they enter into dialogue. I have used it since with the same positive outcome and have found the Wheeler and Chinn process frames and guides the interpersonal process aspects of the action group meetings, irrespective of participant mix or difficulty of subject matter.

At the time of designing the action research component I relied heavily on Carr and Kemmis (1986) and Kemmis and McTaggart (1988) as there was little else available to guide action research. I strayed deliberately from their method on several occasions as I found their method did not ‘fit’ the practice environment in healthcare. As the researcher/participant I accepted the organisational work. I created the first cut at an analysis of any group meeting. I determined in the first instance what it was that we as a group were engaging to discuss. Any or all of these may be seen as transgressing tenets of participatory action research. I maintain, however, they were entirely appropriate to context, where the participants brought what they could best offer, their knowledge of practice and its environment, the very thing I needed but could not otherwise access. I could best offer the administrative and worker-bee tasks and interject the outsider-within questions. All I felt I could ask of the clinicians was that they gave their time for two hours a fortnight for three months and a little reflective time between meetings. It was enough.

More recently the literature on action research has grown substantially and these recent writers have echoed many of my concerns. Winter & Munn-Giddings (2001) “Handbook for Action Research in Health and Social Care”, Christopher Day and colleagues (2002) “Theory and Practice of Action Research” and Reason and Bradbury (2000) in their “Handbook of Action Research” move away from the emphasis in action research on education and into the practice fields of healthcare and social justice and confront the messiness I found in this study. They
provide a greater understanding of the need for flexibility in the real work messy situation, as did I.

We can understand the action research cycle, then, in a way which is both simple and flexible, as a process consisting of just two continuously interacting aspects. On the one hand, there is an immediate practical experience of a situation--; and on the other hand there are attempts (individual and collective) to consider other ways of understanding the experience and consequently) to imagine practical alternatives (Winter & Munn-Giddings, 2001, 14).

Here there is a move to a more “cerebral” change than the practical focus of Carr & Kemmis, a focus on a different understanding. This is consistent with my study where the focus was on an improved understanding rather than an observable change within the practice arena. It is consistent also with a hermeneutic approach where action research provides text for interpretations beyond the interpretations within the group. The consistency with Gadamer is demonstrated in the description given of the interpretation in action research by Winter and Munn-Giddings:

So our basic attitude towards the evidence we collect must be to prolong our sense of its ‘newness’, a sense of not (yet) understanding it. We need to ask ourselves such questions as: ‘what ideas am I bringing to bear on this new experience in order to understand?’ ‘what experiences am I comparing it with in order to make the experience seem familiar?’ ‘how can I understand this differently?’ ‘what other connections could I make?’ (Winter & Munn Giddings, 2001, 211. Original emphasis).

This turn within action research to enable a flexibility that maintains the aims of action research but removes the rigidity of equality of participation, frees action research up to be a methodology of choice in coming to understand the messiness of practice when explored in real-time, working with busy practitioners. This is particularly so when framed by a feminist group process.
The Context:

New Zealand continued to undergo health service reform following 1995. However, it was a reform process that basically wound back most of the changes that had been introduced since 1991 and the green and white blueprint for the reform. By 1997 there were no longer four RHAs with whom to competitively contract, but rather one central body, the Health Funding Authority; CHEs were no longer required to make a profit and their names were changed to Hospitals and Health Services to remove the publicly unpalatable connotation of the Crown Health Enterprise name.

With the advent of the labour government in 1999, the R.H.Ss became District Health Boards (DHBs) and community representation was restored to local health boards, and cooperation not competition was stated as the objective. The focus was to be on the quality of service rather than financial accountability (Gauld, 2001). Much of the damage on the surface has been undone but the human cost of the flirtation with managerialism in healthcare has cost patients and nurses dearly and many wise nurses have been lost to a system that will inevitably take time to recover. The pendulum has swung back but as was said at the time by Roger Douglas, the architect of the public sector reform in New Zealand, if you swing the pendulum hard enough even when it swings back it has gained more ground than any incremental change would have accomplished (Douglas, 1993). And so it has been with health. Budgets are still tight, financial accounting is still a strong feature of health care administration and business processes remain pervasive.

Robin Gauld presents an excellent overview of a tumultuous period in his 2001 book aptly entitled "Revolving doors: New Zealand's Health Reforms".
The Research. Hospital (R.H.):

The hospital, which was the site for this study, changed management structure again shortly after the action research component of the study was completed. All the managers who were there have since left; many of the nurses are still there. A CEO was appointed in 1997 with a health professional background and she has remained since that time. The director of nursing appointed in 1997 was one of the senior nurses from the study and she led the nursing restoration until relatively recently. In a recent communication she told me R.H is working towards magnet accreditation in the future. The senior nurses have not lost sight of the vision and have moved steadily towards it.

The Nursing Profession: A view informed by conversation and observation.

New Zealand is fortunate in having resilient, gutsy nurses who have bounced back albeit wounded. The chief nurse has been a stable and restorative influence, committed to relationship building, coalition building and to health policy influence for nurses. She advises regularly within the Government and the Ministry on policy matters but even so appears poorly resourced within the Ministry. The College of Nurses now dominates the nursing professional speaking space, and is involved with the Ministry and government in policy discussions and policy formation. It is still, however, maintained on the good will of the nurses and is not sufficiently well funded to have full time employees. The union, NZNO, has had a change of leadership and appears to works with the Ministry and the College on most areas of policy development. Issues on which there is not agreement are no longer played out in the public arena.

In 1998 The Ministry for Health established a Ministerial Taskforce on Nursing. The terms of reference were as follows:
To recommend strategies to remove the barriers which currently prevent registered nurses from contributing to a more responsive, innovative, effective, efficient, accessible and collaborative health care service for New Zealanders (Report of the Ministerial Taskforce on Nursing, 1998, 8).

The report of this taskforce created a blueprint for actions that have since been, or are being, implemented. They include competency based practicing certificates for all nurses to assure the public of the quality of nursing practice; the development of models of advanced practice including the introduction of nurse practitioner positions with limited prescribing rights; and the formalising of nurses’ roles in contributing to policy development. This document has paved the way for the primary healthcare initiatives which have taken place with nurses taking a central role, New Zealand based research on workforce with Linda Aiken’s research team at the University of Pennsylvania, and a national project for the introduction of a magnet hospitals recognition process within New Zealand.

These advances in nursing roles and the local research base are important achievements; however, when one looks below the surface most of the changes have been the result of the effort and commitment of individuals. The profession itself remains not securely welded into the political power structures of health in a way that would prevent a repeat of the stripping out of people in key positions as happened in 1993-1995.

What is different is the educational level of a large number of nurses and the research base they are able to bring to their practice and to discussions of health. What is growing is their connection to the community through the primary healthcare strategy and their health policy savvy. Significant numbers of senior nurses now understand Cohen’s stages of political development and Kingdon’s policy streams and work to force the confluence of these streams. Policy entrepreneurship is a skill being role modelled.
The effects on nursing of the events of the time of the reform have been recorded by this study, by a Christchurch study using the methodology adapted from the Sochalski and Aiken’s (1999) International Hospital Outcomes Study examining hospital restructuring form 1988-2001 (Finlayson & Gower, 2002), and by Barbara Mc Closkey in a statistical study undertaken from Yale. McCloskey studied data extracted from New Zealand reports during the time of the reforms and showed that patients were negatively affected by the reforms by using those indicators known as nurse sensitive indicators such as failure to rescue, chest and wound infections (McCloskey, 2003). Together these pieces of research paint a composite picture from which the lessons learned should not be forgotten by nurses or by anyone concerned with healthcare such that the human cost will not be repeated.
Final Word:

Margi, Jocelyn, Frances, Ali, Jenny, Anita, Vicky, Pam and the nurses of R.H., the students and staff of VUW and indeed all the nurses of New Zealand who afforded me the privilege of working with you, sustaining caring, finding regeneration of head, heart and hand after a time of destruction. This story belongs to you.

My admiration, my thanks, my love.

Here is the deepest secret nobody knows:

i carry your heart

i carry it
in my heart

e.e. cummings
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