Shifting (com)positions on the subject of management: a critical feminist postmodern ethnography of critical care nursing

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Southern Cross University

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Shifting (com)positions on the subject of management:
A critical feminist postmodern ethnography of critical care nursing

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A thesis submitted in fulfilment of the requirements for the award of the degree of Doctor of Philosophy

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School of Nursing and Health Care Practices
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Declaration of Originality

I certify that the substance of this work has not previously been submitted for any other degree and is not currently being submitted for any other degree. I certify to the best of my knowledge and belief, this thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

Signed: ........................................

Date: ..........................................
Dedication

To my mother, grandmother, and father who showed me unfathomable depth in relationships and that strength of intellect, courage and morals was in being suprisingly soft, enduringly gentle, loving, and imaginative. And so they forfeited, so that I could have.
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And finally, to my children, who suffered school feeling unwell so as not to upset my study, and who performed miraculous feats like sifting through hundreds of articles to find the spelling of Cartlege on one article (if it was there). Thank you for each being so gorgeously different and for being you—you are my music.
Abstract—Overture

This ethnographic study investigated nurses’ experiences of managing nurses and being managed by nurses within the context of a critical care unit. The four specific aims of the study were to: valorise and make space from which nurses could speak of their management perceptions and experiences; investigate and interrogate the cultural practices and knowledges that comprised and reinscribed the discourses of nursing management; identify the marginal, contradictory or subjugated discourses in the form of alternate or oppositional knowledges and practices embedded in nurses’ experience; and reveal how participants were inscribed by or resisted the various discourses, including the multiple and mobile subject positions they adopted.

The ethnography was theoretically informed by critical, feminist, and postmodern perspectives. Utilising the strategy of writing from the authorial position of occupying a mobile or nonunitary subjectivity, the research highlighted the methodological tensions so as to struggle for social justice whilst contesting the romance of knowledge as cure (Lather, 2000). Music was metaphorically appropriated to interrupt, subvert, and draw attention to the partial, interpretive, and intertextual nature of ethnographic representation and to represent the feminine other in a thesis normatively privileging written text. Conducted over a period of ten months, direct participant observation, individual interviews, and reflective field notes comprised the data. Eleven registered nurses, from all levels of the nursing hierarchy, participated in the study, in addition to the researcher.

The findings of this research revealed nurses experienced feeling abnormal, lonely, angry, and rejected. Interprofessional relations reflected a lack of individual valuing and predominantly vertical violence. Shifting subject positions were primarily informed by dominant instrumental, patriarchal, managerialist, and modernistic discourses that homogenised the identity of nurses and defined the meaning of progress and normal. Management activities were deemed superior to the activities and being of a clinical nurse.

Alternate and subjugated discourses included notions of teamwork, equality, mateship, and viewing management as superfluous and contemptuously. Patriarchal behaviours separating personal life from work life were contested, and behaviours often denigrated and stereotyped as female were valued. Valuing and sharing being human within ordinary nursing work, valuing work for the enjoyment of the work itself, and viewing power as with rather than over were further alternate discourses.

The major implications from this study for nursing as a profession relate to nurses explicitly and foremost valuing their own practice and fostering a culture that genuinely permits individual diversity to alter the existing pre-scripted relations that constrain nurses’ ability to engage in more meaningful interpersonal relations. Questioning current discourses and practices that value specific economic and scientific knowledges, support patriarchal behaviours, and silence nurses is essential. The articulation of alternative discourses that value women and nursing is crucial for reconstructing a reality that does not result in women and nurses feeling abnormal, rejected, and alienated; particularly within the context of a nursing shortage.
This ethnographic study investigated nurses’ experiences of managing nurses and being managed by nurses within the context of a critical care unit. Its intention was to identify and valorize the complex subjectivities and contradictory and marginal discourses embedded in nurses’ experiences and to subvert and contest the unitary, androcentric, dominant notions of nurses’ identity and subjectivity. Dominant forms of knowledge and representation, local knowledges and clinical practices that constituted the multiple discourses that inscribed participant subjectivity and bodily experience were explored and interrogated.

The ethnography was theoretically informed by critical, feminist and postmodern perspectives. Utilising the strategy of writing from the authorial position of occupying a mobile or nonunitary subjectivity the research aimed to highlight and maintain the methodological tensions so as to struggle for social justice whilst contesting the romance of knowledge as cure (Lather, 2000). Music was metaphorically appropriated to interrupt, subvert and draw attention to the partial, interpretive and intertextual nature of ethnographic representation and to represent the feminine ‘other’ in a thesis normatively privileging written text. Conducted over a period of ten months, direct participant observation, individual interviews and reflective field notes comprised the data. Eleven registered nurses from all levels of the nursing hierarchy participated in the study in addition to the researcher.

Nurses experienced feeling abnormal, lonely, angry and rejected. Several reluctantly resigned. Intraprofessional relations reflected a lack of individual valuing and violence that was predominantly vertical. The shifting subject positions primarily reflected the dominance of instrumental, patriarchal, managerialist and modernistic discourses that interconnected and were supported by disciplinary technologies of appraisal, staff development
and meeting systems which homogenised the identity of nurses and defined the meaning of ‘progress’ and ‘normal.’ Management activities were deemed superior to the activities and being of a nurse. Being was not adequate nor certainly being a nurse. Alternate and subjugated discourses included notions of teamwork, equality, mateship and viewing management as superfluous and a little contemptuously. Associated practices were hidden and limited. Patriarchal behaviours separating personal life from work life were contested and behaviours often denigrated and stereotyped to be those of women were valued. Valuing and sharing being human that constituted ordinary nursing work, valuing work for the enjoyment of the work itself and viewing power as ‘with’ were further alternate discourses. Acts of tension and resistance included contesting spatial order and expertise, lack of participation and raising questions. The study is significant for both women and nurses and within the context of a nursing shortage.

**Acronyms**

ACCCN..........Australian College of Critical Care Nurses

AHWAC..........Australian Health Workforce Advisory Committee

ACN ..............Associate Charge Nurse

AIHW..........Australian Institute of Health and Welfare

AONE.........American Organization of Nurse Executives

CEO..........Chief Executive Officer

CNS..........Clinical Nurse Specialist

DEET..........Department of Education Employment and Training

DEST..........Department of Education Science and Training

DEWR..........Department of Employment and Workforce Relations

DHAC ..........Department of Health and Aged Care
DHS.............. Department of Human Services – (Victoria)
DoHA ............ Department of Health and Ageing
DON ............. Director of Nursing
FTE............... Full-time equivalent
ICU............... Intensive Care Unit
HDU .............. High Dependency Unit
NBV............... Nurses Board of Victoria
SCAC ............. Senate Community Affairs Committee
UK............... United Kingdom
US............... United States
Glossary of Terms

Agency nurse—A nurse who is employed by a private organisation and contracted to hospitals requiring casual staff.

Associate charge nurse (ACN)—A nurse who assists and, in association with the unit manager, manages the nursing aspect of a unit or ward. Several positions usually exist on most wards so that ACNs are frequently in charge for shifts in the absence of the unit manager.

Ceiling treatment—A colloquial term referring to a restriction or level placed upon the amount and type of medical care a patient will receive even with deterioration in a patient’s condition.

Charge nurse—A nurse who is responsible for, or in charge of, the nursing aspect of a single unit or ward. Also referred to as a unit manager or first-line manager.

Chief nurse—A nurse who is the most senior nurse within a respective hospital or organisation. The term is sometimes interchangeable with Director of Nursing.

Clinical nurse specialist (CNS)—A nurse who has a high level of specialist clinical expertise and knowledge. Positions are appointed by hospitals that individually develop specific appointment criteria.

Consultant Intensivist—A medical specialist working almost exclusively in ICU and has qualified according to the Joint Specialist Advisory Committee—Intensive care. As the most senior level of medical practitioner, consultants are rostered to ensure one consultant is always in charge.

Executive Director of Patient Care Services—The most senior nurse within a hospital or organisation who has responsibility for nursing services and other patient care services such as cleaning and domestic services.

First-line manager—A nurse who is directly responsible for, or in charge of, the nursing aspect of a unit or ward. Also referred to as a unit manager or charge nurse.

Haemofilter—A complex technical device attached directly into the arteries and veins of patients to filter their blood, often in the presence of kidney failure.

High Dependency—An area of practice that provides care to seriously ill patients who require a higher level of care and observation than can be provided in a ward setting; but who do not require the extent of care given within intensive care. Immediate resuscitation and advanced therapies are available. Sometimes the term is used interchangeably with the term step-down.

Inotropes—Potent pharmacological agents usually administered via central venous or pulmonary artery catheters that alter such things as the rate and contractility of the heart.
Intensive Care—An area of specialty practice that provides care for critically ill patients, usually with unstable and life threatening illnesses. It is a subset of a broader area of practice, that being critical care, which can also encompass such practice domains as emergency, post anaesthesia, dialysis, coronary care and high dependency.

Middle nurse managers—Nurses responsible for an area of three or more wards or units. The term is inclusive of titles such as clinical director and nursing supervisor.

Nursebank—A pool of nurses who work casually or part-time within a specific hospital and are sent to various different areas to work, depending upon the hospital requirements.

Nurse executive—The most senior nurse within a hospital or organisation who is a member of the hospital executive. Also referred to as Executive Nurse or Executive Director of Nursing.

Registered nurse—A nurse registered with the registering authority of their state. A registered nurse has usually completed a three- or four-year course in nursing at Bachelor level or via hospital based education.

Senior nurse manager—A nurse manager who is responsible for more than one unit or ward. Titles include Nurse Supervisor, Clinical Director, Associate Director of Nursing, Chief Nurse, Executive Nurse, and Director of Nursing.

Shooting up—Refers to the injection (shooting in) of illegal drugs into (or up) a vein.

Step-down—The area of care where patients no longer require intensive care on a one nurse to one patient ratio, but where a high level of care is still required. Patients are usually moved to this area in transition from intensive care and before transfer to a ward area.

Supervisor—A nurse who oversees or supervises other nurses. This may be of several units or of an entire hospital.

Swaned—A colloquial term that implies a pulmonary artery catheter (of which one brand is a Swan Ganz) is in situ.

Trachy change—The changing of one tracheotomy tube (a device for assisting air entry located into the trachea in the anterior aspect of the neck) usually for another.

Unit manager—A nurse responsible for, and usually in charge of, a single unit or ward. Also referred to as a charge nurse.
Chapter One

Introduction—*The prelude*
Introduction to the thesis—Notes of introduction

This introductory chapter provides a frame of reference and background to this ethnographic study of eleven nurses’ embodied experience of managing nurses and being managed by nurses. The ethnography is theoretically informed by critical, feminist and postmodern perspectives, which are fluidly combined or integrated with intention to subvert and trouble fixed boundaries. Trinh (1989) depicted this boundary fixing problem in summatting that “despite our desperate and eternal attempt to separate, contain, and mend, categories always leak” (p. 94). Utilising the strategy of writing from the authorial position of occupying a mobile or nonunitary subjectivity, the study aims to draw attention to the partial, interpretive, and intertextual nature of ethnographic representation. The chapter initially provides some general background including metaphoric notions and the braided or entwined relationship of the research and researcher prior to defining the aims of the research. The impetus and significance for the study is then described followed by an explanation of the styles utilised within the thesis. The chapter concludes with an explanation of key terms and a brief overview of the content of each chapter.

Sounds from the background—Blowing in the wind

This thesis is concerned with the management of nurses, in particular the experience of managing nurses and the experience of being managed by nurses. In exploring my thesis topic, I recognised as I progressed that my topic, or the particular way I had chosen to pursue the subject-matter, concerned human relationships. The topic essentially involves the experience of interpersonal relationships that exist between nurses and nurse managers, and the larger context that influences these relationships. During the journey of the thesis, multiple paths unfolded as to how I could proceed. I intentionally and with difficulty chose to include critical, feminist, and postmodern insights into the ethnography as I grappled with critical and feminist intentions and postmodern perspectives. The final product I view as a work of art, not in the sense of its aesthetic beauty, but in the sense of its individual creation. Notwithstanding this point, its development created some concern for me as I wanted to ensure I gave voice to nurses, or more accurately that I created space from which nurses could speak. I finally conceded that I could not claim to author either nurses’ individual or collective truth, but could only attempt to represent these multiple voices. Examining my own subjectivity also became problematic as I acknowledged that subjectivity itself is also both multiple and mobile. This thesis is therefore written from the authorial position of a nonunitary or mobile subjectivity (Bloom, 1998; Ferguson, 1993). By positioning myself as author with a mobile or nonunitary subject, I attempted to subvert the notion of depicting a real reality or a description of truth whilst simultaneously acknowledging myself and topic as twin construction inextricably enmeshed in the research (Richardson, 2000), and yet still
having the burden of authorship (Geertz, 1988). The use of multiple perspectives assisted to elucidate alternative interpretations which may have escaped consideration in providing a unified version of reality (Savage, 2000). I have, therefore, constructed the ethnography not as an objective description but have attempted to locate myself and to roam freely in the research, to trouble constraining boundaries, to reflect the complexities, and to recognise and draw attention to the interpretive and partial views depicted in the text.

This thesis is openly acknowledged as being a self-created textual representation. As a representation it allows human agents to share a world of understanding, but in this writing act of signifying or attempted duplication of thought something is always lost in the transfer (Mitchell, 1990). Despite my best intentions at textual writing, I acknowledge that this thesis defies much of what I cannot linguistically put into words and is simultaneously an intertextual construction. As Mitchell stated “representation is that by which we make our will known and simultaneously that which alienates our will from ourselves in both the aesthetic and political spheres” (p. 21). I have therefore, as a strategy, metaphorically appropriated notions of music within the thesis to intentionally interrupt and subvert the written text. I attempt to draw attention to the limitations of text with the reminder of the aesthetics of music.

Music is perhaps my closest but humble claim to artistic endeavour. Music can represent pleasure, pain, beauty, emotion, and intangibility. As a mode of communication, music can often portray meaning that linguistics cannot capture. Music is both cultural and yet transverses cultural boundaries. The theatre of music defies any textual representation with the individuality of its performance. It can be performed, recorded, and replayed but the replication or simulacra defy exact replication to its individual perceptions. Music is suspended in the fourth dimension of time-space, free of any obligatory response by the listener and represents endless possibilities (Updike, 1994). Music can be the sound of waterfalls, wind in the trees, or the call of a bird. As a form of expression, music can represent both individuality and interconnectedness. Music can share meanings resistant to verbal expression and communicate meaning where linguistic text falls short. Music therefore represents the aesthetics in relationships that textual representations omit. I sit with my son at the piano as we play a simple duet. I sense his quiet joy that is reflected in his shining eyes—if only we could play forever. I sit with my mother and sister at my grandmother’s funeral. The carefully but painfully selected music plays as we anguish and draw comfort together. Again I sit at the piano—seeking solace; all I want to do is play. My baby is dead and I feel some relief in music that I cannot find elsewhere. Chinn (1994a) noted that “the perspective of the arts opens the mind and heart to possibility. It taps the
deepest regions of the spirit, where the heart of the self can be felt, touched, nurtured and inspired” (p. 28).

Throughout the thesis I intentionally situate and intertwine myself within the text writing in the first person to acknowledge myself as author as intrinsically enmeshed in the research but also to acknowledge the twin construction of reality that this thesis evokes (Richardson, 2000). Music construed as feminine represents language’s repressed other.

Music and the body are intrinsically linked, for the human body—moving, vibrating, breathing, talking, shouting, whispering, clapping, singing, dancing—is always in a state of music … The visual world to which language belongs takes precedence over the auditory world.

(Macarthur, 1995, pp. 121-122)

The appropriation of musical metaphors also attempts to highlight and give some privilege to auditory representation in a text that mandates visual representation.

**Aims of the study—The intentions, endeavours and desires**

This critical ethnography sought to answer the broad research question, that being what are nurses’ experiences of managing nurses and being managed by nurses? To do this, the study focused on exploring the local knowledges and clinical practices that constituted the discourses of nursing management within the specific cultural context of a critical care unit.

Whilst ethnography is the reproduction or rewriting of culture, this research, rather than just describe the culture, sought to specifically interrogate the management culture of nursing within a critical care unit, given that the notion of culture within this study is held to be fragmentary and in constant transition.

The four specific aims of the research were to

- valorise and make space from which nurses from all levels of the hierarchy could speak of their management perceptions and experiences;
- investigate and interrogate the cultural practices and knowledges that comprised and reinscribed the discourses of nursing management;
- identify the marginal, contradictory, or subjugated discourses in the form of alternate or oppositional knowledges and practices embedded in nurses’ experience; and
- reveal how participants were inscribed by or resisted the various discourses, including the multiple and mobile subject positions they adopted.

The notion of lived experience utilised in this study is that lived experience is a construction, “a particular locus stratified by discourse, desire and physical experience” (Fox, 1993, p. 110). Rather than the traditional detached and objective position of researcher/
ethnographer, I attempted to locate myself in the research to reflect the complexities and to recognise and draw attention to the interpretive and partial views depicted.

**Impetus—The inspiration and motif**

*Instead of fictions of representativeness, shielding a will to mastery in commentary, it is important to ask, following Foucault, under what institutional and historical conditions do writers come to be authors?*  

(Lee, 2000, p. 196)

As a critical care nurse, my thoughts regarding nursing management became challenged whilst undertaking a Masters Degree in Health Administration. Studying for the first time outside of the discipline of nursing I was significantly impressed that the course coordinator was a nurse. I inquired as to how she had gained this status among so many impressive and well-published non-nurse academics. It was explained that she was not much of an academic.

I was stunned by this rather demeaning perception of administrative work, which was totally foreign to my knowledge of administrative and management work that I had gained from my 22 years of clinical nursing experience within public and private hospitals. Similarly, it contrasted with how I had perceived coordination to be viewed within university schools of nursing. The thought that administration and management could be viewed differently outside the cultural context of nursing, and that different contexts of management existed, inspired my exploration.

At the time, and for the last 10 years, I have (now rather humbly) coordinated a critical care nursing course from within a university that graduates approximately eighty nurses a year to work within critical care areas. Most nurses that graduate from critical care courses leave the clinical field of critical care practice within five years (Williams, Ogle & Leslie, 2001). As a nurse and a woman this concerned me as many students enter the course with the intention, desire, financial and emotional commitment of developing knowledge and expertise to provide them for a long term career in this nursing specialty.

In previously exploring nurses’ attraction to, and attrition from critical care nursing, I found nursing management was cited as one factor that led to attrition (Turner & Ogle, 1999). I did not believe, however, that nurse managers intentionally sought for this to occur. With a continual shortage of critical care nurses (Australian Health Workforce Advisory Committee [AHWAC], 2002; Australian Institute of Health and Welfare [AIHW], 2003a; Department of Health and Aged Care [DHAC], 2000; Department of Human Services [DHS], 1997b, 1999a; Williams et al., 2001) most nurse managers had implemented strategies to overtly attempt to attract and maintain nurses (Williams et al., 2001). Having worked in a clinical capacity and in nursing management positions within a variety of nursing institutions,
together with having studied health management, I was also aware of complex political and contextual issues that constituted the social reality of nurses. Medical dominance (Willis, 1989), nursing oppression (Ashley, 1980; Hedin, 1987; Lee & Saeed, 2001; Roberts, 1983), horizontal violence (Attridge, 1996; Duffy, 1995; Roberts, 2000, Skillings, 1992), gender issues (Chinn, 2000; Glass, 1998, Speedy, 2000) and what may be termed tribal contests or conflicting interest groups (Beattie, 1995; Degeling & Anderson, 1992; Robinson-Walker, 1999; Sax, 1989) were all power issues within the complex organisational contexts of hospitals. My brief exploration of the literature identified an almost absence of nurses’ voices, perspectives, or experience either in respect to managing or being managed. It did identify, however, the oppression also of nurse managers (Roberts, 1997; Silvetti, 1990). As the issues were politically situated and complex, I sought to explore the culture of nursing management from the clinical field, and the embodied experiences of nursing management from the perspectives of both nurses being managed by nurses and of nurses who were managing nurses. My concerns for nurses as women resonated with that of Glass (1998) in the double oppression of being a female in a male dominated world, as well as being a nurse in a subordinated health occupation. My impetus therefore to conduct and author this study arose from a concern for both women and nurses.

**Significance—The performance of a politics of pleasure**

The critical intentions of this study are both teleological and political. The desire to improve the everyday lives of nurses, to eliminate features of oppression and injustice, to work towards transforming the social order (Fay, 1987) and toward greater equality are explicit political agendas of the research. As a nurse and a woman I am committed to the right and desire to make space from which nurses can speak.

Moving from silence into speech is for the oppressed, the colonised, the exploited, and those who stand and struggle side by side, a gesture of defiance that heals, that makes new life and new growth possible.

(hooks, 1990, p. 340)

Nurses make up the single largest occupational group in most acute care hospitals and are the largest workforce in Australia’s health care system (AIHW, 2003a), yet there has been very limited research into nursing culture (Suominen, Kovasin & Ketola, 1997). With changes in the health care industry there have been many studies on medicine; however few on the less esteemed allied professions and semi-professions. Within the health care sector, women are by far the majority who work in gender segregated occupations and who produce the bulk of patient care (Brannon, 1994). The invisibility and silence of nursing has been well documented (Attridge & Callahan, 1989; Bradley, 2001; Buresh & Gordon, 2000; Chiarella, 2002; Jolley & Brykczynska, 1993; Lawler, 1991a; Watson, 1994). By making space for
nurses to speak of their experiences and analysing the sociopolitical context of the clinical culture in which nurses work, manage, and are managed by nurses, this study sought to provide insights into the culture of nursing management.

This research is also very timely and of immediate practical significance. The shortage of critical care nurses is both a local concern (DHS, 1999a, 2001), and a national and international concern (AHWAC, 2002; Buchan & Edwards, 2000; Buerhaus, Staiger & Auerbach, 2000; Department of Employment and Workplace Relations [DEWR], 2004;; Department of Education Science and Training [DEST], 2001; DHAC, 2000; Finlayson, Dixon, Meadows & Blair, 2002; Kimball & O’Neil, 2002; Senate Community Affairs Committee [SCAC], 2002; Williams et al., 2001). The turnover rate of hospital nurses has risen in the United States [US] (Nursing Executive Center, 2000), and it is thought to be in the range of 18% to in excess of 30% in critical care units in the United Kingdom [UK] (Cartledge, 2001) and Australia (Crockford, 1989; Mathews & Campbell, 1990; Meijis, 1992; Williams & Clarke, 2001; Williams et al., 2001). Turnover rates usually only measure hospital resignations and exclude transfers to other units within the same hospital. Unit separations have been demonstrated to exceed the turnover rate by an additional 40% and as a measure of retention may more accurately depict problems of staff disruption (Taunton, Boyle, Woods, Hansen & Bott, 1997).

Many further nurses are reported to be contemplating leaving the profession, with management cited as one factor contributing to this occurrence (DHS, 2001; SCAC, 2002). Furthermore, the recent National Review of Nursing Education (DEST & Commonwealth Department of Health and Ageing [DoHA], 2002) proclaimed “the most crucial factor in ensuring an adequate supply of nurses for the future will be to retain as many of those nurses currently employed as possible, particularly those in the earlier years of their career” (p. 13). The most recent comprehensive study regarding Australian critical care nurses, The Critical Care Workforce in Australia 2001-2011 (AHWAC, 2002), estimated (utilising attrition models of 10% and 15%) a current Australian shortfall in excess of 500 nurses and recommended both improving the supply of critical care nurses and strategies to improve the retention of critical care nurses. Mills and Blaesing (2000) aptly noted that with nursing shortages attention is often focused on quick solutions to recruit more nurses rather than to the historical problem of poor retention. This study will provide timely insights into the experiences of critical care nurses, the clinical culture of critical care nursing and, in particular, focus on the issue of the management of critical care nurses.

The critical and feminist insights and intentions of the study are of considerable consequence for women. The valorisation of women’s local, individual and plural experiences, as well as the broader critique of discourses and the construction of women’s subjectivities within the
sociopolitical context, affirms one of the feminist intentions of the study, that is, to benefit women. Feminist research should be embedded in human experience (Flax, 1999), is carried out for women (Webb, 1993), and should be of some benefit for women (Bunting & Campbell, 1994).

Critical, feminist, and postmodern insights that interrelate and display the intersection of power, discourse, and subjectivity in the management culture of critical care nursing are depicted in this study. Alternate, contradictory, subjugated, and marginalised knowledges and practices embedded in nurses’ experiences are surfaced. In this process both the inscription and resistance of subjectivity through discourse is shown. Unitary, androcentric dominant notions of nurses’ identities and subjectivities are subverted and contested to valorise alternate more complex multiple subjectivities or subject positions. This provides nursing and nurses with the possibility of challenging existing power structures, practices, discourses, and subject positions which constitute the individual nurse’s experience.

**Outline and styles of the thesis—Composing of the score**

The styles used within this thesis are consistent with the American Psychological Association [APA] Publication Manual, 5th ed., 2001. The referencing system utilised is the author-date system. Author surnames have been treated according to the rules of the language of origin as per 4.04 APA Publication Manual (p. 219). The direct transcription of the words of participants is represented in Arial font. Reflective field notes are represented in Book Antiqua font, whilst the remainder of the thesis is represented in Times New Roman font. The thesis has been written in the first person to acknowledge and direct attention to my authorship, and therefore the interpretive and representational nature of the thesis. By writing in the first person I also seek to acknowledge the twin construction of myself and the topic entwined within the research (Richardson, 2000).

Several strategies have been utilised in an attempt to subvert the notion of constructing a linear and unitary truth or reality. Music has been metaphorically appropriated to interrupt the textual representation with reminders of the aesthetics, the loss that occurs in any interpretive process, and the limitations of visual textual representations. By positioning myself as the author with a nonunitary or mobile subjectivity (Ferguson, 1993), I have attempted to contest fixed boundaries and categories and to subvert notions of a singular truth. Conversely, I have endeavoured to reflect the complexities within the research and to recognise and focus attention to the interpretive, partial, and intertextual views depicted in text.

Chapter one provides a frame of reference to the reader, including a brief introduction and background to the study. The aims of the study are stated, together with a brief outline of the
impetus for the study and its significance. This chapter is concluded with a description of the styles and content of the thesis. Chapter two provides a background to the context of the study, firstly in respect to the larger sociopolitical context of the current health care system and the organisation of and within hospitals, and secondly, more specifically in regard to the local context and site of this ethnographic study. Discourses of management that appear in the literature, including the terms of leadership and administration, are then explored and critiqued in chapter three. Chapter four follows with an examination of the social organising within organisations and of nursing and nurse management that exist in the literature. A more traditional review of the current literature is cited in chapter five with the few specific studies of nursing management within critical care highlighted.

The theoretical framework and methodology is explicated in a detailed and extensive chapter six in order to describe and discuss the integration of critical, feminist, and postmodern perspectives that are brought to and inform the study. The borders of these theoretical perspectives are also troubled and problematised in comparing and discussing notions of agency and subjectivity. The authorial position of a nonunitary or mobile subject is described in detail in this chapter. Chapter seven builds upon the theoretical perspectives of chapter six and describes the application of these theoretical positions within the ethnographic approach. This chapter explicates the specific method of the study including the selection and access of the ethnographic site and recruitment of the eleven nurse participants. The methods of data collection, that being participant observation, reflective field notes, and semi-structured in-depth interviews, are described prior to a description of data analysis. Chapter eight comprises the data and discussion inclusive of nine subject positions that could be identified as adopted by nurses. A discussion of the relationship between the data and literature is interwoven throughout this chapter. The final and concluding chapter is chapter nine, which reflects upon the aims of the study and the extent to which they were met. It discusses the significance of the findings and makes suggestions for both action and research. Tensions within the study are examined and the validity of the research is discussed. This final chapter concludes with my personal reflections.

**Key terms—Tuning to shared meanings**

The understanding of concepts brought to this thesis are that social meanings are social constructs that are negotiated and understood by individuals as they live, experience, and communicate with others collectively and individually throughout their lives. Given the perspective that each individual is composed of many subjectivities and adopts multiple shifting and fluid roles, the meaning attached to a concept may differ for the same individual according to the particular subject positions or roles of that person at that time. It is false to
assume that concepts are stable in their meaning over time and between contexts and that they are neutral in the way they operate (Paley, 1996). For this reason, only a limited glossary that attaches and fixes static meanings to terms and concepts is included within this thesis. In addition and despite this multiple and fluid understanding of social meaning two central concepts are now traditionally defined as similar to the glossary they are key terms and further explication of the understanding and meaning brought to these terms within the context of this thesis will assist the shared understanding of these terms between the reader and author.

Nursing management is conceptualised within this thesis to refer to the performance of a role, position, and the functions of a formally designated appointment within an institution or health care agency as a nurse manager. This term contrasts with the concept of leadership, which is not an officially designated appointment. The term implies a relationship between the nurse manager and other nurses which is further discussed in chapter three where these terms within the current literature are critiqued.

Critical care is conceptualised within this thesis to broadly refer to the specialty of nursing focused on the care and treatment of critically ill patients and encompasses nurses working in intensive care units [ICUs], postanaesthetic recovery rooms, emergency departments, renal dialysis departments, and air-medical and retrieval teams (British Association of Critical Care Nurses, 2001; Australian College of Critical Care Nurses [ACCCN], 2002a). The definition of critical care is often used interchangeably with the term intensive care. This is further discussed in chapter two in the historical development and context of critical care nursing.

**Summary**

This introductory chapter has provided a frame of reference for the reader of this thesis. The chapter commenced with some background and introductory information, particularly in relation to the issue of textual representation and the use of music as a metaphor within the thesis. The aims and objectives of the research were listed prior to the impetus and significance of the research being discussed. Finally, an explanation was given of the styles utilised within the thesis, key terms were defined, and a brief outline was given of the form and content of each of the chapters within the thesis.
Chapter Two

Contemporary contexts of the study—

Surround(ing) sound
Introducing the contexts—Background music

In this chapter the contexts in which this ethnographic study were situated are briefly explored. As the research study was conducted in Victoria, Australia the context is focused on this particular locality, however, where appropriate, global issues are also identified. Initially, the broad sociopolitical issues and trends within the Australian current health care system, particularly as they impact upon nursing, are outlined. This precedes a discussion of the global concern and imperative of economic rationalism, health care cost curtailment, and the corporatisation of health care. Specific contemporary factors affecting nursing and the organisation of hospitals, including the impact of technology, the shift to increased casual and contractual employment, the shortage of nurses, and the lack of diverse cultural representation and gender constitution of the nursing workforce, then follows. Recent initiatives of clinical practitioners and coordinated care trials are viewed from the perspective of attempts to increase professional status. A brief discussion of the historical and current context of critical care nursing is given, and finally, a specific description of the critical care unit in which this ethnographic study was conducted concludes the chapter.

The context of the Australian health care system—This is Australia

The Australian health care system is characterised by a mixture of both private and public systems for the funding and delivering of health care services. Medicare has been in operation now for 20 years and is a universal public system primarily funded by the Commonwealth Government. In addition, 43% of the population hold private health insurance, although this rate is falling (Private Health Insurance Administration Council, 2003). Australia spends approximately 9.3% of its gross domestic product on providing health care, which is comparable to other Western countries and less than the US that spends approximately 13% of its gross domestic product on health care (AIHW, 2003c).

Despite the relative performance of the health care system, consistent concerns are raised regarding current quality of care (Australian Council for Safety and Quality in Health Care, 2001; Curtin, 1996a; de Crespigny, Emden Drage, Hobby & Smith, 2002), waiting lists to enter hospitals (AIHW, 2003b), length of time patients spend in emergency departments (DHS, 1999b, Grech, Pannell & Smith-Sparrow, 2001), issues of access to the health care system (Armstrong, 2002b), and the health of particular groups within the population. The mortality and morbidity rates for Aboriginal and Torres Strait Islander people are a major cause for concern, being two-and-a-half times those of the non-Aboriginal Australian population (Clinton & Nelson, 1998). In addition, there is concerted worry regarding containing future health care costs and the impact of technology with an ageing population (Senate Community Affairs Reference Committee, 2000). Whilst there is some debate
regarding the actual financial impact of an ageing population with some opinions indicating it is rhetoric and a scare strategy (Leeder as cited in Armstrong, 2002b), it is estimated that the number of people in Australia aged over 65 will increase from 13% to between 27% and 30% by the year 2051 (Australian Bureau of Statistics, 2003). Technology and the effect of an ageing population, particularly on pharmaceuticals, are both defined as major contributors to what is expected to be increasing health care costs (Commonwealth Department of Treasury, 2002). In addition, there is strong competition, continual negotiation, and positioning for scarce resources among many interest groups within the health care system that belies rhetoric and public images of rational health policy development and application (Degeling & Anderson, 1992).

In order to curtail health care costs, government initiatives have been to move toward a market system introducing notions of user pays to eliminate moral hazard that is overuse, and to introduce competition into the provision, delivery, and management of health services (Armstrong, 2002b). This has also been consistent with other government initiatives outside of the health sector in Australia to privatise and encourage competition with the assumption that there will be improved efficiency and a reduction in costs. Improving the delivery of healthcare by being business-focused and devoting attention to market share, strategic plans, labour issues, and corporate success reflects global trends outside of Australia (Clint & Nelson, 1998; Dye, 2000; Tuohy, 1999). Problems and politics in the British National Health Service [NHS] (Antrobus, 1997; Mackay, 1989; NHS, 2000; Owens & Glennerster, 1990; Tuohy, 1999), Canada (McPherson, 1996; Romanow, 2002; Tuohy, 1999), and the US (American Nurses Association, 1999; Moses, 1988; Tuohy, 1999), have resulted in studies of nursing organisation and numerous restructures as governments attempt to improve the efficiency and quality of care within their respective health care systems. Concerns regarding the sale of public hospitals to the private sector (Sellers, 1997) and of the complete corporatisation of health care within Australia by large private health management organisations based in the US buying into the Australian market has also been raised (Uren, 1997).

Simultaneously in Australia, whilst the medical profession continuously battles to maintain professional control of the health care system, illness prevention rather than just medical cure has gained some prominence, consumer groups are demanding some voice, and outcome and performance measurements have become the focus (Ackroyd, 1995; Crichton, 1990). Chief executive officers of hospitals who traditionally held a medical degree are being replaced by persons with formal training in hospital management and administration, and professional backgrounds in accounting and business (Mackay, Soothill & Webb, 1995). Indicators of hospitals outputs and performance measures are required to be collected and reported by
each of the Australian state health departments which are responsible for the management of their respective hospitals (DHAC, 2001). Health care management has become very business-focused with cost containment, managed care, cost efficiency, evidence-based care, clinical indicators and other economic measurement and output terms prominent discourses. Carter (2001) noted “payers [of healthcare] have become keen negotiators for the lowest price within an acceptable level of quality” (p. vii).

Organisational restructuring to matrix management structures within health care institutions has reflected corporatisation and sought to devolve management decision making to include senior medical clinicians in resource management and thereby improve efficiency and effectiveness (Clinton & Nelson, 1995). Casemix management, following a modified version of that developed at Yale University, was first formally proposed for introduction into Australia in the Medicare Agreements of 1988 (Hathaway & Piccone, 1995). Whilst many states in Australia prepared their health care management structures for casemix management with restructuring of area health boards, health networks, matrix style staffing organisations and clinical clustering, Victoria was the first state to commence a prospective funding model linked to casemix management. Whilst this funding is only a small proportion of all hospital funding, casemix management and the development of patient classification systems, that is, diagnostic related groups (DRGs), was introduced with the aim of gaining information, measuring hospital performance, and increasing efficiency and effectiveness through managing competition and costs (Hovenga, 1995).

Measurement of some aspects of hospital performance linked with strong economic rationalism has led to health care institutions and health care networks attempting to accommodate this by operating as corporate businesses. The promotion of equality and diversity are policies of most health care organisations, however, Baxter (2001) noted “the primary selling point of the effective management of diversity is its potential to help an organisation achieve its business objectives” (p. 11). In a similar manner, Bridge (1998) contended that many nurses working within occupational health and safety have adopted a corporate orientation promoting their services on the basis of anticipated cost-benefits. Managing demand (Edwards & Hensher, 1998), emphasis on outputs and results, standards and empirical measures of performance, greater market competition and contracting, and stress on private sector style management practices has become the overt current public model of health care (Bates, 1998; Buchanan & Considine, 2002; McCoppin, 1995; Timpson, 1996; Turkel, 2001).
**Context of hospitals—*Waltz of the flowers***

Hospitals and health care organisations have responded to the economic imperatives placed upon them. In recent years there has been the development of links with the community and deinstitutionalisation, initiation of hospital in the home programmes, and the concepts of managed care and clinical pathways have been developed and implemented. Outpatient procedures and day surgery has dramatically increased whilst average length of stay within a hospital has decreased now to 3.6 days (AIHW, 2003b). There has been an increase of 10.5% in patient separations per full-time equivalent (FTE) nurse in public hospitals (AIHW, 2001; DHS, 2001). This has resulted in increased workloads for nurses with the rise in patient throughput and acuity, and also increased the specialisation in the work of nurses (DEST & DoHA, 2002).

The rapid promotion and advances in technology, particularly medical technology, has also had a significant impact on hospitals and the work of nurses. Walters (1995) argued that nursing practice is “technologically textured, particularly in the acute hospital setting” (p. 388). Nurses now work within technical systems and live in a world that is increasingly organised in accordance with efficiency and logical order (Barnard & Heron, 2001). Technology has transformed hospitals into specialties so that many environments of nursing practice within a hospital are defined by machine technology including haemodialysis and the ventilator, which is usually only associated with critical or intensive care (Barnard, 2000). The dehumanising aspect of technology is discussed by (Cooper, 1993) who asserted that nurses identify with the values imposed by technology and that in intensive care the dominance of technology renders many experiences of care invisible or obscured. Technology requires that nurses develop new skills and introduces new options in care whilst it alters and de-emphasises other nursing skills (Barnard, 2000).

> Although technology offers nurses real and worthwhile indicators of the physical condition of the patient, an excessive reliance on technology can reveal itself as the tendency to accept quantitative evidence obtained from machinery and equipment in preference to, and in spite of, the qualitative evidence of the thoughts, experiences and feelings of the person.

(Barnard, 2000, p. 169)

The rapid technological growth in information and communication systems has particularly affected hospitals with electronic health records, computer networking to speed and share communications, computer databases, and Internet usage. The growth has been spectacular, particularly within the areas of clinical information systems and management information systems (Graham, 1995). The Commonwealth Government, in conjunction with the US, has made a commitment to support the further development of information systems within the
health care sector (DHAC, 2001). Health is an information-rich industry, and those who control the information control the industry such that, for nurses, literacy in information and communication technology is essential (O’Brien, 2001; Hovenga, 2001). Hovenga (2001) also noted a by-product of this information technology “enabl[ing] analyses of data to determine effectiveness and efficiency of nursing activity … which complements the use of controlled clinical trials and fits with priorities related to customer focus and health outcomes and the aims of the evidence based practice movement”(p. 40). The introduction of computerised information technology into ICUs has often been argued to be cost effective in respect to saving nurses time for manual documentation (Marasovic, Kenney, Elliot & Sindhusake, 1997). Few studies have demonstrated any clear cost benefits of any such computerised systems (Harrison & Nixon, 2002).

Within the hospital, and in the larger social environment, technical performance and proficiency is highly prized and respected. Nursing as a profession has sought recognition and respect by accepting new roles and responsibilities originating from new technologies and from the reassignment of duties from medicine associating itself with technology and scientific progress. It is often argued nurses have sought status from technological and medical management at the expense of marginalising basic nursing care (Stevens & Crouch, 1998). Furthermore, nurses are often highly respected for their technological skills to operate special machinery and equipment, particularly if they are the only health care workers with these skills (Barnard, 2000; Fairman, 1992; Stevens & Crouch, 1998). However, this extended role of nurses in relation to medical technology in intensive care or upskilling can also be described as work intensification (Harvey, 1995).

Another constituent factor of the social context that has impacted upon hospitals is the current trend for the casualisation and contracting of employment arrangements. According to Burgess and McDonald (1990), the increase in casualisation of employment has occurred in the general population in the female dominated service sector leading to employee marginalisation. There has been an increasing trend towards employment for nurses to be part-time, casual, contractual though nursing agencies, or through use of nurse banks or pool systems (AIHW, 2003a; Bates, 1998; DHS, 2001; Snell, 1997). The proportion of nurses engaged in part-time work (that is, less than 35 hours per week) increased from 48% to 54% between 1995 and 2001 (AIHW, 2003a). This casualisation of the nurse workforce has led to lack of continuity of care whilst contributing to strain and increasing the workload of nurses (DHS, 2001).

Salvage (1990a), in response to the nursing shortage that existed in Britain over 10 years ago, advocated for nurses to be able to select flexible part-time employment and to abandon the “male model of unbroken full-time service … in favour of practices that help the working
woman to manage her double shift of home and job” (p. 1478). Bates (1998), however, noted the tenuous position of what she terms a *peripheral* labour force in nursing in respect to lack of sick leave and lack of entitlement to notification of retrenchment for casual nurses. Furthermore, she claimed that with the drive for efficiency and functional flexibility within hospitals, casual employment assists the hospitals’ need to manipulate numerical and functional flexibility of nurses contributing toward greater profitability and efficiency.

The decrease in hours being worked by nurses has been accompanied by and also contributes to the level of work intensification, leading to more nurses seeking work casually or part time in order to spend less time in the workplace.

(Hawksworth as cited in Harulow, 2000, p. 29)

The increase in part-time and casual work may be surmised to reflect lifestyle choices, indicate budget considerations, and represent an attempt by nurses to have some control over their workload (DHS, 2001).

Victorian hospitals have also been set in a context of industrial action and negotiation by the Australian Nurses Federation for an enterprise agreement, which resulted in an Australian Industrial Relations Commission ruling in August 2000 that strongly focused on issues of nurse recruitment and retention. The ruling invoked nurse patient ratios and many short-term measures to improve the working conditions and retention of nurses, as well as more long-term strategies for the ongoing monitoring of the workplace including the work of casual nurses. Agency nurses have increased due to nurse dissatisfaction with the bullying, role erosion, poor working conditions, and pitiful wages of hospital employment when agency nurses have more flexibility and can earn up to $200 an hour (Copley, 2002). The intensification of agency nurses resulted in agencies charging up to $265 per hour for critical care and specialist nurses and within Victorian hospitals approximately 7% of FTE have been estimated to be agency staff (SCAC, 2002). Due to the rising cost of agency nurses and in response to the ruling of the Australian Industrial Relations Commission, the Victorian state government in April 2002 initiated attempts to restrict public hospitals from utilising agency nurses and encouraged hospitals to further develop their own nurse banks. Hospitals were instructed by the Victorian Department of Human Services that agency nurses were not to be used except to cover sick leave and in exceptional circumstances, with an anticipated saving of up to $20 million per year (SCAC, 2002).

**Contexts of nursing—*Where have all the flowers gone?***

The most significant issue surrounding nursing in the context of this study is the international, national, and local shortage of nurses at times described as being at a crisis point (American Organization of Nurse Executives [AONE], 2003; Coffman, Spet, Seago,
Rosenoff & O’Neil, 2001; Finlayson et al., 2002). Internationally initiatives that have subsequently resulted from this include significant advertising campaigns and financial support to educate more nurses under the Nurse Reinvestment Act in the US (Servodido, 2001), the introduction of nursing ratios and workplace reform in California (Tieman, 2001), and numerous workforce restructures and studies (Buchan & Edwards, 2000; Buerhaus et al., 2000; DEST, 2001; DEWR, 2004; DHAC, 2000). The World Health Organisation (2003) has identified, with concern, the increasing flow and active recruitment of nurses from developing countries to industrialised countries when the developing countries themselves have insufficient numbers to meet their own workforce demands.

With this focus on the shortage of nursing in Australia, two large national studies have been instigated by government bodies, being the Senate Inquiry into Nursing (SCAC, 2002) and the National Review of Nursing Education (DEST & DoHA, 2002). In addition, a national forum entitled Rethinking Nursing was sponsored by the Commonwealth Government (DHAC, 2000). The respective health departments of numerous states have also recently been prompted to conduct extensive studies into their nursing workforce (Department of Health and Human Services Tasmania, 2002; Department of Human Services South Australia, 1998; DHS, 1999a, 2001; Health Department of Western Australia, 2001; NSW Health, 2001a, 2001b; Queensland Health, 1999). Furthermore, studies by professional organisations and nurse registration boards have been conducted, together with studies that attempted to aggregate, validate, and link complex data sets with known discrepancies (Buchanan & Considine, 2002; Johnson & Preston, 2001; Nurses Board Of Victoria [NBV], 1998; Ogle, Bethune, Nugent & Walker 2002; Williams et al., 2001). These studies focused on investigating issues of workforce planning, including attempts to aggregate data to quantify shortages and further examine recruitment and retention of nurses. Issues in nursing education, including the quantification of undergraduate and postgraduate nursing students and projected graduates, have been examined together with specialty practice areas within Australian nursing.

The report from the National Review into Nursing Education (DEST & DoHA, 2002) identified that Australia should expect a shortfall of 31,000 nurses by the year 2006. Recommendations from the numerous studies are extensive and include improved nurse labour force planning together with the collection and compilation of appropriate and timely workforce data (DEST & DoHA, 2002; DHS, 2001). Improved communication and planning between states, the commonwealth, health service providers, education providers, and government departments, and the inclusion of a chief nursing officer or a national body to provide a national voice, leadership, and coordinate long term nurse workforce planning was recommended (DEST & DoHA, 2002; DHAC, 2000; SCAC, 2002). Remuneration to
recognise the complexity of nursing work, the introduction of nurse practitioner positions, improved articulation pathways, and additional funding and places for transition, undergraduate and postgraduate programs, and research were also recommendations of the studies (DEST & DoHA, 2002; SCAC, 2002).

Simultaneously, and as a result of some of the studies, recruitment strategies have been advocated to improve the image of nursing and to augment the number of nurses in the workforce by attracting new and existing nurses back into the workforce. However, most studies overwhelmingly have acknowledged that one of the major problems is the working conditions of nurses, including the workload and the environment (Buchanan & Considine, 2002; DHS, 2001; SCAC, 2002). Whilst there has been some success reported with attracting nurses back into hospitals (Moyes, 2003), it was reported in 2001 that of “the 69,000 nurses with current registration in Victoria, more than 13,000 are not currently employed in the nursing workforce” (DHS, 2001, p. 1). Illife (2001) noted “we do not have a shortage of nurses in Australia. What we do have is a shortage of nurses willing to work in the system as it currently is” (p. 1).

The attrition rate of both young and experienced nurses is a concern with many nurses reporting to be contemplating leaving the profession. Management was cited by nurses as one factor contributing to this occurrence (Buchanan & Considine, 2002; DHS, 2001; SCAC, 2002). There is currently also a shortage of rural and remote nurses, midwives, and particularly some specialist nurses. Critical care nurses are almost always listed on any study investigating nursing shortages (Buchanan & Considine, 2002; DEST & DoHA, 2002; DEWR, 2004; DHS, 1997b, 1999a, 1999b, 2001; Ogle & Ferguson, 1996; SCAC, 2002). In response to these issues and the mounting shortage of nurses in particular specialties, the Australian Health Ministers Advisory Committee commissioned specific studies into midwifery and critical care nursing.

The Critical Care Workforce in Australia 2001-2011 study (AHWAC, 2002) estimated the current national shortage of critical care nurses to be in excess of 500 and noted there were 460 current vacancies. Several models were utilised to predict future workforce requirements with premised attrition rates of 10% and 15%. Major recommendations from this report included an increase in the supply of critical care nurses, retention measures to retain critical care nurses in the workforce, and improved data collection to facilitate enhanced workforce planning.

The increase in the number of public and private critical care beds is a contributing factor in the shortage of critical care nurses with data indicating that there has been an increase nationally of 300 available beds between 1997 and 2000 (AHWAC, 2002; Anderson & Hart,
2002; DHS, 2001). This is unlike the US which decreased its total number of ICU beds by 7.2% (American Hospital Association, 2001). Factors identified as specific causes of attrition within critical care units include excessive night duty and limitations to lifestyle choices, political and managerial changes within the critical care arena, the practice demands, inappropriate remuneration, lack of career structure and opportunity, and devaluation and lack of autonomy (AHWAC, 2002; DHS, 2001; Turner & Ogle, 1999; Williams et al., 2001; Wong, 2001).

Whilst there is a shortage of nurses available or willing to be employed within Victorian hospitals, the workforce remains predominantly female gendered with only 8.4% of total registered nurses being male, and is ageing with the average age of nurses increasing to 42.2 years (AIHW, 2003a). The average age of a critical care nurse in Australia is slightly younger than other nurses being 37 years. The gender balance differs slightly also with males constituting 12.4% of all intensive care/critical care registered nurses. Males similarly comprise 12.4% of all nurse administrators (AIHW, 2003a). The constitution of the nursing workforce is not representative of the cultural diversity of the Australian population (Hendy, 1997). Nurses from Croatian and Vietnamese backgrounds are particularly underrepresented within the nursing workforce (Tang et al., 1999). Furthermore, non-English speaking background people are underrepresented in nursing and in tertiary nursing courses, such that nursing should respond, recognising language and cultural diversity as normal and on-going (Department of Employment Education and Training [DEET] & Department of Health and Community Services, 1994; DEST & DoHA, 2002). Australian nursing is not inert from Puzan’s (2003) apt description of the reproduction and institutionalisation of white cultural privilege. The context of nurses and nursing within the Australian workforce therefore should be considered for its age, gender, and cultural bias.

Nursing groups representing nurses have a long history of an agenda for further recognition of the value and worth of nurses and nursing, and to increase the professional status and autonomy of nurses. Whilst this struggle has been torturous and contentious (Cohen, 1981; Forsyth, 1995; Salvage, 1985; Schwirian, 1998; Short & Sharman, 1989; Turkoski, 1995), several current initiatives may be considered aligned to this quest. Nurse practitioner trials with nurses performing advanced nursing functions have commenced in several states including Victoria where they were first introduced in 1998. The term independent was omitted from the title early in the formulation of the role where medical concerns were aroused and it was stipulated that projects would not directly compare services provided by nurse practitioners and medical practitioners (Chiarella, 1998). One nurse practitioner project in Victoria is the ICU liaison nurse practitioner model to case manage the discharge of patients from intensive care and to bridge the gap between intensive care and the wards. This
role includes the ordering of diagnostic tests and the adjusting of specific medications following clinical practice guidelines which has been reported to have increased ICU bed availability, reduced the number of preventable ICU readmissions, identified and corrected patient problems, and provided support and education to ward staff (Transancos et al., 2002). Case management and coordinated care trials, the latter supported by both state and federal health departments, are other recent initiatives. Nurses are usually not permitted to assume the role of care coordinator except for the Aboriginal and Torres Strait Islander care trials which are the exception and where one is geographically unlikely to find a doctor (Gleeson, 1997). Furthermore, according to Gleeson, these initiatives are also expected to improve efficiency and reduce costs by coordinating care and preventing cost shifting. The Senate Community Affairs Committee, at the completion of its overview, stated

Nurses have had to cope with the effects on patient care of increasing demands being placed on health services through constantly contracting budgets. Yet nurses have little opportunity to participate in the formulation of policies to deal with or address these changes. It is time for the nursing profession to be recognised as an equal player in Australia’s health care system. It is time for the voice of nurses to be heard.

(SCAC, 2002, p. xvi)

The historical development and context of critical care nursing—
Yesterday’s songs
A Swedish study that explored everyday practice in intensive care utilising a social constructivist perspective noted that intensive care was produced by routine practices with a marked division of labour, shared understandings between personnel that made words redundant, and coordination between personnel and the technological equipment. Personnel both produced and reproduced intensive care through constant sense-making in the here-and-now, at the same time as the past was present in their activities (Wikström & Larsson, 2003). Most definitions of critical care, however, are realist and many display some confusion with the definition of critical care and intensive care. The terms are often used interchangeably; however, the term critical care can denote differing meanings that are not always explicitly stated. According to the British Association of Critical Care Nurses (2001) and the ACCCN (2002a), critical care nursing can be loosely defined as that specialty of nursing focused on the care and treatment of critically ill patients and encompasses nurses working in ICUs, postanaesthetic recovery rooms, emergency departments, renal dialysis departments, and air-medical and retrieval teams. This broad definition given by professional bodies serves the purpose of appealing to a broad group of nurses and potential large membership. However, the Consultative Council on Emergency and Critical Care Services (1990) defined critical
care units as “an area specifically staffed and equipped for the continuous care of critically ill, injured or postoperative patients” (pp. 20-21), and units may be subdivided into ICUs, intensive care step-down units, coronary care units, and high dependency units [HDUs]. Emergency, recovery, and dialysis areas are not incorporated within this definition of critical care, and furthermore, critical care is a group of units not only intensive care or synonymous with intensive care.

The NBV (1998) noted this problem, derived their own definition which also very broadly included spinal, renal, orthopaedic, and neonatal care, and called for the Australian national nursing organisations to develop a nationally accepted nomenclature for all areas of specialty practice, including critical care. Despite this, a large amount of literature utilises the terms interchangeably and without explicating their exact meaning. For the purposes of this research, critical care refers to the broad definition adopted by ACCCN (2002a), and therefore literature is drawn from this larger body to inform the study. The term intensive care is understood to be a subgroup within critical care and is utilised to explicitly denote “an area specifically staffed and equipped for the continuous care of critically ill, injured or postoperative patients … who require mechanically assisted ventilation and have a high likelihood of requiring systems assistance technologies” (Consultative Council on Emergency and Critical Care Services, 1990, pp. 20-21).

Intensive care is a complex multidisciplinary activity with the goal of providing for and treating life threatening illnesses, however its development has been uncontrolled, haphazard, and variable with very little planning at either a regional or national level (Reis Miranda, Ryan, Schaufeli & Fidler, 1998). Williams (1998) noted that “it is the epitome of high-tech medicine and frequently portrayed as the place where life-saving miracles are frequently wrought” (p. 1). Critical care units first evolved within American and European hospitals in the 1950s and 1960s (Fairman, 1992; Reis Miranda et al., 1998; Zussman, 1992) and within Australian hospitals in the 1960s (DHS, 1997b; Wiles & Daffurn, 2002).

Traditional nursing practices of intensive observation, spatially arranging unstable patients in close proximity of nurses, and triage of patients, however, can be traced back to the late eighteenth century, despite medical accounts which render nurses’ work invisible and unacknowledged (Fairman, 1992; Fairman & Kagan, 1999). Increased hospital utilisation and financial gains to be made from the insurance boom induced hospitals to build single rooms and to transform multipatient wards into single rooms that then prevented nurses from continually observing patients in their wide open spaces and disbanded the prior informal patient reporting system that occurred from stable patients (Fairman, 1992). With limited reorganisation or economic investment, hospitals chose to formalise the intense observation of unstable patients by putting nurses, critically ill patients, and equipment together in an
architecturally distinct area (Fairman, 1992; Fairman & Kegan, 1999). Once organised, special care areas quickly became official medical spaces under medical control with the authority to determine when patients required intensive nursing care rather than nurses with their traditional method of triage (Fairman, 1992; Harvey, 1995). The Society of Critical Care Medicine was not founded until 1972 and the first American Medical Association board only began to certify specialists in intensive care in 1986 (Zussman, 1992).

ICUs are an organisational innovation concentrating staff to care for the most critically ill patients and may be likened to a mini-world within the larger hospital world, being complete with their own staff and equipment, as well as being semi self-contained (Zussman, 1992). ICUs proliferated from existing only in large hospitals to being established in smaller hospitals, and from the public sector to private hospitals. They also proliferated in number within larger hospitals, establishing units that specialised in cardiac, neonatal, paediatric, medical-surgical, thoracic, trauma, neurology, or a mixture of these specialties (Bennett & Bion, 1999; Zussman, 1992). Recently in Victoria there has been a trend toward hospitals geographically combining critical care resources and the specialties into fewer but larger units, despite research indicating increased nursing staff turnover in larger units (Jolma, 1990) and the research study of Reis Miranda et al., (1998) which recommended that the size of ICUs ideally be 9 beds, or at least between 6 and 12 beds. Australia and the UK have a lower per population ratio of intensive care beds, and a lower proportion of total hospital beds are intensive care beds (1-2%), compared with the US (20%) (Intensive Care Clinical Implementation Group [ICCG], 2001). This reflects the higher acuity of patients in Australian and UK ICUs where the nurse-patient ratio is usually 1:1 (Bennett & Bion, 1999). Some European and US units have a nurse-patient ratio of 1:2 or 1:3 where usually there is a large proportion of low risk patients (Bennett & Bion, 1999; Endacott, 1996).

Critical care units were established to improve quality of care and decrease mortality and medical costs by concentrating facilities, resources, and technology together (DHS, 1997a; Myers, Schroeder, Chapman & Leong, 1984). Despite the fact that they are usually the most expensive ward in the hospital after the operating suite, their complexity and a traditional philosophy of preserving life at all costs and at all times (Birnbaum, 1986) has contributed to very little effective determination of their actual benefits and costs (Bennett & Bion, 1999; Elliot, 1997; Reis Miranda et al., 1998; Zussman, 1992). The increased accountability of professionals and the drive for cost containment, however, is likely in the future to cause a mismatch between funding and the increase in complex surgery and requirements of an ageing population (Bennett & Bion, 1999).

Nurses working within critical care units are required to make very rapid clinical decisions (Bucknall, 2000) and often enjoy the intellectual stimulation (Turner & Ogle, 1999). Most
nurses working within ICUs in Australia have completed a formal qualification of study in intensive care or critical care nursing (Williams et al., 2001) with almost all the courses being conducted within universities in collaboration with hospitals (NBV, 1998). Intensive care nurses have a long history of a desire and drive for further knowledge which has also contributed to a perception of their higher status within nursing and the hospital hierarchy (Fairman, 1992). However, the extended role of nurses in ICUs represents occupational flexibility whereby a more powerful profession (medicine) makes use of the labour of a subordinate group to carry out tasks that do not get incorporated into the subordinate group’s core skills so that neither their real status nor autonomy is enhanced (Harvey, 1995; Stevens & Crouch, 1998).

Initiatives have been driven recently within the Australian professional organisation of critical care nurses, that is, the ACCCN, to improve the status, recognition, voice, and communication of critical care nurses. These have included the development and revision of research-based critical care competency standards based upon the Australian Nursing Council competency standards (ACCCN, 2002a; Dunn et al., 2000), the development of a national process of credentialing nurses (ACCCN, 1999), and a position statement on intensive care nurse staffing (ACCCN, 2002b). The formulation and contribution to establishing an international society of critical care nurses, being the World Federation of Critical Care Nurses, has also been a recent endeavour (Williams et al., 2001). The particular context of the ICU where this study was undertaken is now described.

The locale of the intensive care unit—*Where do broken hearts go?*

This study was undertaken in a level III general ICU (Joint Faculty of Intensive Care Medicine, 2003) that comprised one ward of a large public teaching hospital in Melbourne, Australia. The hospital had a long esteemed tradition of educating nurses, doctors, and allied health professionals. In recent years, with the move of nursing education to the university sector, the hospital was affiliated with several universities in providing undergraduate clinical nursing experience or practicums and conjointly offering specialist postgraduate clinically-focused nursing courses. The hospital alone facilitated both nurse education and research with continuing education, the offering of short nursing courses, nursing research scholarships, and the employment of staff specifically with education and research functions.

The hospital contained several high acuity patient care areas. The unit in which this study was conducted was a general ICU that received and cared for patients with a wide variety of complex critical illnesses including general medical, surgical, trauma, neurological, and road trauma. The specialities of paediatrics or neonatology were not offered within the unit. At the time of this study the hospital was in the midst of quite extensive rebuilding and
refurbishment so that construction sites and renovations were readily apparent and required frequent negotiation. A component of the rebuilding project incorporated plans to combine several of the critical care areas. At the time of completion in writing this thesis the unit staff had been integrated with other critical care units and staff into a new larger unit and to a new locale.

The critical care unit where this study was located physically contained between 10-16 bed spaces, however not all of these beds were considered open or staffed all of the time. The availability of open beds depended upon patient requirements, funding, and availability of critical care nursing staff. During the winter months a further bed was often opened or designated as a critical care bed to accommodate the expected increase in intensive care admissions over this time. Most of the beds were dedicated to the care of intensive care patients with a minority designated as step-down, that is, they were allocated to patients who were not as critically ill and did not require mechanical ventilation. Nursing staff cared for patients in the whole unit; however, allocation to work within the step down area was not a popular claim of staff.

There were between 80-100 nursing staff rostered within the unit, most of whom worked rotating shifts between day, afternoon, and night duty. Night duty was usually rostered for two weeks after each period of four weeks of day duty. A few permanent staff worked only night duty, however, this practice had been discouraged and the advent of permanent night duty staff was a fairly new occurrence. Nursing staff employed within the unit were usually required to work all shifts. Specific requests for shifts could be sought; however, they could not always be accommodated. A system of banking additional hours worked operated within the unit whereby the unit attempted to staff itself primarily from within the unit. Nursing staff could work on their rostered days off if they were called by the unit and bank the hours to be taken later as time off in lieu or a day off when the unit did not require them. This process also attempted to reduce the unpopular occurrence of staff being sent to work in other areas of the hospital outside of the critical care unit, enabled staff familiar with the unit to be called in busy times, and was a cost effective method of staffing the unit. Many of the staff worked four shifts per week. This was considered to be a normal workload rather than five shifts per week, and was consistent with the national average of hours worked by permanent intensive care nurses (Anderson & Hart, 2002). Some nurses supplemented their work within the unit by working also for an external nursing agency at times convenient for themselves or according to their financial requirements.

Nurse educators were specifically employed to provide continuing education to the staff of the unit, as well as to provide orientation for new nursing staff to the unit. In addition, the nurse educators provided lectures and clinically supervised nursing students undertaking
postgraduate degrees in critical care nursing in affiliation with a local university. Nursing staff comprised one unit manager, several associate unit managers, clinical nurse specialists, and clinical nurses who were all registered nurses, some undertaking critical care studies. On each shift there was usually allocated a resource nurse with the specific function of clinically providing resources and supporting staff and who was not allocated a specific patient to care for unless a new admission required this.

Geographically the unit was oblong in shape with a central corridor that divided two rows of bed cubicles. Each cubicle was divided by a semi-partition that separated the bed areas. The ends of beds were open to the corridor which was the site for charting, general patient observation and staff discussion, and therefore was a frequent spatial position of nursing staff. This enabled nursing staff to talk to other staff in adjoining and adjacent bed areas whilst simultaneously being able to view new or other existing occupants of the length of the corridor. The central workstation was positioned toward the middle of the unit, breaking the continuity in the rows of beds. It housed patient histories, x-rays, staff rosters and communication books, and was the focal area for administration and documentation of the daily running of the unit. In addition, the unit contained a small office utilised by doctors and for formal family meetings, a small office for the unit manager, a very small nurse education office, a stores and equipment area, plus a small tea room containing a quasi kitchenette. This tearoom was also the site for handover, staff meetings, various committee meetings, and for the advertisement of professional and social activities.

**Summary**

This chapter has provided a broad overview of the contexts in which the study was situated. The international and national issues of health care corporatisation, economic rationalism, and concerns for cost curtailment that are impacting on the Australian health care system were discussed with its effect of creating dominate discourses that may be aligned with private business management. Notions of improved efficiency, productivity, market share, competition, output measurement and performance standards, including the sway to evidence based and casemix management practices were outlined with particularly reference to nursing. Factors influencing the organisation and operation of hospitals, including the increased throughput of patients and shorter length of average stay, which has resulted in the increased work of nurses, was outlined. The rise in medical and information technology, the international and national shortage of nurses including nurses who work in particular areas of specialty practice, and the increase in casual and contractual work of nurses was reviewed. The recent concern with nursing workforce issues was outlined, including the recent major national and state inquiries into nursing and the industrial action that resulted in a ruling from the Australian Arbitration Commission. The rise in use of agency nurses was outlined,
together with initiatives of the Victorian government to curb their costs and growth. In examining the constitution of the nursing workforce, it was recognised that the nursing workforce is almost exclusively female, is ageing, and displays a lack of cultural representation compared to the Australian population. The history of critical care was briefly examined noting that nursing practices of intense observation and triage preceded the development of medically dominated architecturally distinct critical care units which are frequently reported in historical accounts but render nursing invisible. Nurse practitioner projects, credentialing, competency standards, and the development of a world federation of critical care nurses are recent professional initiatives of critical care nurses. Finally, the chapter provided an overview of the hospital and specific description of the critical care unit which was the context in which this ethnographic study was situated.
Chapter Three

Discourses of nursing management—

*Reviewing the multiple melodies*
Introducing the literary discourses—*Mixed and multiple melodies*

*Why do we find it congenial to speak of organisations as structures but not clouds, systems but not songs, weak or strong but not tender or passionate?*

(Gergen, 1992, p. 207)

This chapter is the first of three chapters that reviews the literature in respect to the experiences of nurses in both being managed by nurses and of managing nurses. In order to provide a comprehensive review of the literature that not only describes recent research but also critiques and interrogates what has and has not been written, and to include an analysis of the discourses informing the multiple perspectives, this review is divided into four sections.

The first two sections are contained within this chapter, that initially commences with an analysis and critique of how the terms leadership, administration, and management are defined and utilised within the literature, and particularly in respect to nursing. The intent is to depict the numerous perspectives that contest a fixed meaning to these terms and to identify inherent relations of power. The second section of this chapter briefly examines the current literature in respect to discourses of management within organisations, and specifically in respect to studies of nurses as the experiences of the participants of this study occurred within the context of a large health care organisation.

The third section comprises chapter four and discusses the current research and literature that specifically focuses on the social organising of nursing including the identity and value of nursing work, the professional status, and the structural and cultural relations of nurses specifically in relation to nursing management. This aspect is highlighted as sense making is historically constructed within an institutional frame and may be visible in the practices of personnel and the expected order of such things as the division of labour, organisation of work, rules, and regimes (Suchman, 1998). The fourth and final section which comprises chapter five shares similarities with traditional instrumental quantitative literature reviews and explicitly examines nurses’ experience of managing and that of nurses’ experience of being managed, including the limited literature pertaining to critical and intensive care nursing. Despite attempts to delineate sections of the literature, at times some areas overlap due to their intricate interconnection. For example, notions of horizontal violence are predominantly spoken of in chapter four in respect to the social relations of nurses; however, they also resurface in specific studies of critical care nurses in chapter five.

Rather than review only literature that may be termed *scientific studies*, the literature reviewed in this chapter and consistent with the theoretical framework is inclusive of
research, theoretically informed scholarly literature and, where appropriate, anecdotal accounts and expert discussion. Similar to the findings of Vance and Larson (2002), a comprehensive search revealed that most of the literature published on leadership and management in healthcare is descriptive. Key seminal literature is also included with the overall intention to provide a broad contextualisation of the discourses and a critical summation of what has been documented within the literature. The provision of a comprehensive literature review has permitted the inclusion of small voices that are often poorly represented in traditional reviews and those that frequently focus on large empirical studies. These small voices include individual accounts of experience and small descriptive studies from non-Western countries. The inclusion and prominence of these smaller studies has been intentional, rather than perpetuate their exclusion or relegation to the end of the review as an afterthought.

Consistent with the theoretical framework of the thesis, the chapter is written from the perspective of an author with a mobile or nonunitary subjectivity so that I freely roam from and between feminist, critical, and postmodern perspectives of the literature. A comprehensive search revealed a paucity of literature specifically pertaining to the experiences of nurses in managing and being managed by nurses within ICUs. However, numerous texts and an increasing amount of literature and research were obtained regarding nursing management and leadership.

**Definitional discourses of management, administration, and leadership—**

**Shifting pitch**

The terms management, administration, and leadership are frequently utilised within nursing and organisational literature, however, their definition within the literature itself reflects differing assumptions and conflicting discourses. According to Cuthbert, Duffield, and Hope (1992), the terms management and administration are alike however, within Australia, management has usually referred to private enterprise, whereas administration has been the term favoured in public enterprise. The current nursing literature, however, reflects little mention of administration and displays prevalence towards discourses of management and leadership. The term administration currently refers only to a formal position or the role attached with performing that formal position within a hospital or institution, unlike leadership and management which are behaviours, attitudes, attributes, roles, and skills that many authors argue a nurse should aspire to in her career, and to learn to excel in (Dye, 2000; Fagin, 2000; Sullivan & Decker, 2001).

Nzimande (1990), in investigating the evolution of administration in nursing, noted that administration and management are not clear and consistent terms. She argued that
specialists and professionals are more likely to see themselves as managers and disparage the title of administration with its connotations of public administration. However, within nursing in South Africa administration is viewed as distinct and of superior status to management, with all administrators managing but not all managers having administrative power. Only the most senior nurse is referred to as an administrator and other levels of nurses whose work involves administrative functions are titled first line or middle managers.

Furthermore, management and leadership are often terms used interchangeably in the literature by some authors (Clark & Copcutt, 1997; Clinton & Nelson, 1998; Dye, 2000; Fagin, 2000; Sullivan & Decker, 2001). They have been cited as areas of study that overlap (Huber, 2000; Girvin, 1998; Yoder-Wise, 2003), and have been depicted as distinct and separate areas of study by others (Kotter, 1990; Laurent, 2000; Rost, 1994). Hersey, Blanchard, and Johnson (1996) and Bleich (1999) viewed management as a subset of leadership, whilst Cuthbert et al., (1992) viewed leadership as a subset of management. Clinical leadership is a recent addition to these definitional arguments. The obscurity and preference for leadership as a term is evidenced in research undertaken by Cook (2001) who stated, “clinical activity sets the clinical leader apart from the ‘generic’ nurse leader, who is defined as a ‘nurse that creates new ways of working,’ and nurse manager, which refers to ‘implementing new ways’” (p. 39).

Klenke (1996) defined leadership as “a role performed by an individual who exercises influence within a system in order to accomplish goals that flow from a vision and which are based on values” (p. 12). Numerous definitions of leadership are apparent and have originated from a variety of leadership theories, including trait theories (Stogdill, 1974), charismatic theories (Davidhizar, 1993), relational theories (Covey, 1998; Greenleaf, 1998), contingency theories (Fiedler, 1967; Vroom & Yetton, 1973), transactional theories (Burns, 1978), transformational theories (Bass & Avolio, 1993; Burns, 1978; Dunham & Klawehn, 1990; Kouzes & Posner, 1999; Trofino, 1995), connective theories (Klakovich, 1994), and post-industrial theories (Rost, 1994; Starratt; 1993). Kreitner and Kinicki (1998) aptly noted disagreement about the definition of leadership stems from the fact that it involves a complex interaction among the leader, the followers, and the situation. Some researchers define leadership in terms of personality and physical traits, while others believe leadership is represented by a set of prescribed behaviors. In contrast, other researchers believe that the concept of leadership doesn’t really exist. There is a common thread, however among the definitions of leadership. The common thread is social influence.

(Kreitner & Kinicki, 1998, p. 495)

This notion of social influence is evident in almost all definitions of leadership, with leadership effectiveness defined as goal achievement (Cuthbert et al., 1992; Drucker, 1996).
Tappen, Weiss and Whitehead (2001) summarised this as “the essence of leadership is the ability to influence other people” (p. 4).

Leadership is differentiated from management according to Kotter (1990) as leadership is a process that focuses on organisational change, while management is primarily concerned with control and results. Furthermore, according to Kotter, leaders are the stimuli behind an organisation’s adoption and adaptation to improved processes and therefore being a leader is preferable to being only a manager. This preference for leadership is again noted in the assertion that leaders do the right things, whereas managers do things right, and leaders focus on effectiveness, whereas managers focus on efficiency (Bennis & Nanus, 1985; Marriner Toney, 2004). The nursing leader strategically and passionately plans a vision where the manager is the operations function to get it done (Spitzer as cited in Huber, 2000). Porter-O’Grady (1997) proposed the death of management, advocating instead leadership. An elitist element is accorded to leadership by Koenenbaum (1991) who described leadership as being relevant to everyone but that only a few understand it and even fewer choose it. Rost (1994) noted leaders to be portrayed as extraordinary people who are well developed and highly principled, achieving complex goals incomprehensible to the sweaty masses. The nursing literature uncritically depicts leadership as futuristic, progressive, and proactive, and leaders as active change agents, whilst management is discredited with these attributes. According to Onsman (2002), leadership is usually depicted as a higher-purpose activity with an almost moral dimension to the task, as sexier than management, and is a fundamentally elitist notion. Most leadership literature can be viewed to reflect discourses of positivism and rationality in respect to change, improvement, and progress. Nursing literature has predominantly reflected this.

**Definitional assumptions of leadership relationships—I’m the leader of the gang**

All definitions of leadership include the notion that there are followers (Yukl, 1981), and emphasise that the nurse can only claim to be a leader when they have followers (Drucker, 1996; Smith, 1985). However, some of the relational, post-industrial, and connective notions of leadership have refined and emphasised the nature of this relationship focusing on collaboration instead of followers (Klakovich, 1994; Rost, 1994), have inverted the leader to a servant of the follower (Greenleaf, 1998; Spears, 1998), or described a leader-associate relationship (Elliot, 2002). Greenleaf’s work also incorporated the notion of wholeness where the servant-leader’s responsibility was to build common ground and rebind everyone as healers of a fragmented society. Feminist notions of leadership highlight the relational aspect and contest the male orientation that dominates most leadership literature depicting the successful leader as aggressive, forceful, competitive, and independent (Bormann, Pratt & Putman, 1978; Calás & Smircich, 1992; Hartsock, 1983; Putman & Heinen, 1976;
Shewsbury, 1987). Duerst-Lahti and Kelly (1995) noted that leadership has been defined in terms of masculinism, to the disadvantage of women, and has given men and masculinity a privileged position in interpersonal institutional relations. Leadership studies have measured success according to criteria that is within the status quo (Starratt, 1993). Held (1993, 1997) advocated abandoning the dominant economic man contractual relationships that currently exists in public social relationships and corporations for a feminist model of social relationships that is based upon morality and mother-child relationships. Wheeler and Chinn (1989) also provided an alternative model for nursing based upon feminist principles of group-process and consensus building where leadership was a constantly rotated position within a group.

Apart from the model of Wheeler and Chinn (1989), Laurent (2000) proposed what could be identified in the literature as the only other nursing theory for leadership and based her model upon Orlando’s model of nursing. She asserted that nursing theory has focused on managing patients, which is about control and getting the job done with the effect that nurses are good managers or controllers but that they have promoted, mentored, and modelled management rather than leadership. Her theory comprised a dynamic leader-follower relationship where the leader released some control. Laurent made no comment regarding the benefits of adopting this model to patient care rather than managing patients, which would be the corollary to her argument and essentially entailed a change in human relations.

Whilst not always explicitly stated, the main differentiation between leadership and management discerned from the literature was that leadership might occur without an officially designated position of authority (Girvin, 1998; MacPherson, 1991; Rost, 1994; Tappen et al., 2001). Girvin (1998) denoted this as “a position of authority in the organisation does not automatically confer leadership” (p. 64). Rost stated that management is located within an organisation whereas leadership can occur anywhere, however this differentiation reifies an organisation to something else than the social interaction of people. According to Dye (2000), the distinction between leadership and management in reality is semantics as all leaders manage and all managers lead. Cuthbert et al., (1992) noted that managers, because of their formal position, have legitimate authority to demand the cooperation of subordinates. Duerst-Lahti and Kelly (1995) described this as “holding a position of public authority places one in a leadership role in governance by virtue of positional power alone” (p. 15). Institutionalised authority relations within a hierarchical pattern lead to expectations that leaders will and are obliged to define the reality of others to be considered effective (Smircich & Morgan, 1982). Currently, leadership discourses are usually associated with notions of influence, whereas management is associated with notions of control (Laurent, 2000), which is often bound to the argument that professionals wish to
be led but not managed (Kerfoot, 2002). It can further be argued that both leadership and management involve the exercise of power in a relationship, but that the mechanisms or techniques of how influence is accomplished differ.

Nursing continually calls for better leaders and leadership, which is a recurring theme in the literature (Borbasi & Gaston, 2002; Girvin, 1998; Irurita, 1994; Kitching, 1993; Lett, 1999; Mahoney, 2001; McCormack & Hopkins, 1995; Wright, 1996). Girvin noted that previous leaders have been blamed for a multitude of dissatisfactions – clinical grading, education changes, crises in recruitment and retention, inadequate pay, poor conditions, lack of power, and difficulty for nursing in controlling its own destiny. This she attributed to the historical and social forces that have shaped nursing resulting in nurses exerting tight control over the mass of the workforce, largely by the power of their position. There [has] been few opportunities for nurses to develop leadership styles other than those related to the traditional power of position and rank, and ‘command and control’ styles.

(Girvin, 1998, p.49-50)

Despite the espoused notion that leadership does not require a designated formal position, it appears that nursing literature attests to nurses only recognising leadership to occur within formal designated positions of administration or management. Dean (1993) contested this and the notion of a shortage of nursing leaders, arguing that nursing does attract and comprise leaders but they largely go unrecognised. He argued that advanced clinical practitioners, research and development nurses, and clinical practice development nurses have often forged their own paths yet are usually unrecognised for their leadership due to the expectation that leaders leave clinical practice.

Salvage (1990b) and Fedoruk and Pincombe (2000) also noted the years of socialisation and tradition that has contributed to nurses continuing to think in hierarchical terms. Fedoruk and Picombe advocated for nursing to take a visionary leadership role rather than a management role, however, they note that it will require a change in the perception of the collective consciousness of health care agencies to enable this. How this is to occur is not detailed except that courage is identified as the most important quality needed by the nurse leader of the future. Considering leadership has been called for in nursing for over 10 years (Kitching, 1993), there is an omission in the literature as to why currently managers are not leading, or why leaders with or without management positions are not developing. Structural and gender factors have been depicted, however, in line with the positivistic depiction they are usually portrayed as historical. Borbasi and Gaston (2002) depict a different view and argue that senior nurses, private, public, and academic are now more than ever constrained by their respective boards and are therefore “constrained in the political arena because they can’t speak out”(p. 33).
**Definitional assumptions of leadership, vision and goals—*Working for the man***

Vance and Larson (2002), in an extensive 30 year computerised search and review of the research on leadership in business and healthcare, noted a strong bias toward viewing leadership as a causal force in organisational performance and a key factor in producing outcomes. They noted the assumption that leadership is without meaning except as it serves the function of facilitating performance, organisational change, and goal achievement.

Bennis (1989) stated that a guiding vision is the first basic requirement of leadership, which is similar to most definitions of leadership which emphasise or include initiating change, having a vision, promoting the vision of the organisation, inspiring others toward this vision, and influencing others (Dye, 2000; Girvin, 1998; MacPherson, 1991; Starratt, 1993). Murphy and DeBack (1991), in a comprehensive synthesis of the leadership literature, listed *managing the dream* as a core and the first competency of leadership. Parry (2002) attested that leaders transform the hearts and minds of their followers. Charisma, selling, storytelling, using allegories, fables, parables, analogies, creating heroes and heroines, changing perception, and communicating the vision are also documented as important for leaders (Bass & Avolio, 1993; Bennis & Nanus, 1985; Bleich, 1999; Drechslin, 1996; Hersey et al., 1996; Kouzes & Posner, 1999; McDaniel & Wolf, 1992; Neuhauser, 1993). Starratt (1993) described leadership as drama. The leader’s vision should be clear, attractive, and attainable (Bennis & Nanus, 1985). The unstated assumption in these descriptions of leadership is that this *vision* is consistent with the accomplishment of organisational goals. To be an effective leader by definition requires the achievement of the organisational goals (Cuthbert et al., 1992). Similarly, Drucker (1996) contended that the only way for management to justify its existence is through economic results. This provides little benefit to the follower or consideration for other social, quality of life, or environmental factors (Alvesson & Willmott, 1992; Jackson & Carter, 1992).

**Positivistic leadership—*Moving on up***

The passion and enthusiasm or positive attributes accredited to the concept of leadership are strongly evident in the nursing literature. Yoder-Wise (2003) described leadership as vital for nursing and that the public and nurses depend upon nurse leaders. Mahoney (2001) advocated that “possessing advanced knowledge in leadership skills will open doors to a fulfilling future” (p. 271). It is summated by Starratt (1993) who stated that leadership is “essential for modern democratic institutions and societies … [Without leadership] intuitions and societies lay themselves open to demagoguery and totalitarian rule” (p. 14). Meindl, Ehrlich, and Dukerich (1985) and Dunford (1992) noted a romanticised conception of leadership, asserting that we greatly exaggerate the effect of leadership as people like to attribute outcomes to the result of comprehensible human agency. They further claimed that
it is an established part of the way people explain events in organisations. Few authors have discussed or acknowledged the dark side or negative aspects of leadership. Whilst many workers have experienced a boss who abuses this power, very rarely is it noted in the literature, and if it does, it is glossed over (Clements & Washbush, 1999; Onsman, 2002; Parry, 2002). According to Berg (1998), there is an “exaggerated need to promote leadership and to silence whatever haunts us about the notion of followership” (p. 28). Leadership is strongly associated in the literature with success, achievement, and risk, however, rarely is failure mentioned (Chaffee & Arthur, 2002). The only nursing leadership literature that acknowledged the potential abuse of the power relations of leadership identified was Reinhardt (2004) who, in a theoretical argument, reconstructed transformational leadership through a postmodern discourse.

**Leadership and power—Everybody wants to rule the world**

Whether power is acknowledged in association with leadership varies in the literature, however, it is seldom linked in nursing notions of leadership. Barker (2002) clearly states in his analysis of leadership that “leadership then when broadly conceptualised, is the exercise of power … [and] influence is the prime leadership tool” (p. 52). Power-like leadership is a relationship between leaders and followers, both involving motivation, resources, and influence (Trofino, 1993). Within nursing literature, power is often mentioned negatively. Girvin (1998) asserted that when leaders influence their followers’ behaviour in order to meet their own goals, they are exercising power and stated “if, when they are influencing to achieve goals, leaders also manage to satisfy the motives and needs of their followers, they are exercising leadership” [italics added] (p. 16). Most definitions of leadership assume that both organisational and each individual follower’s motives and needs are compatible. Research conducted by Argyris (1993) has contested this, displaying that individuals gave priority to meeting their own goals and that multiple rationalities and motivations exist in organisations. This is further supported by Carter and Jackson (1993), Clegg (1989), Dunford (1992), Jones and May (1997), Georgiou (1973), and Pfeffer (1981). Cousins (1987) stated “management itself is not a monolithic entity but made up of groups which may have competing interests” (p. 39). Watkins (1986) noted that leadership has been utilised to clothe senior managerial positions in a charismatic mantle that reinforces and legitimates the role and social practices as natural whilst detracting and mystifying the unequal power relations that exist in many organisations and stated “a ‘motherhood’ term like leadership can obscure the seduction and subversion carried out in the name of administration” (p. 31). Giddens (1982) also noted that the term leadership has been utilised to veil unequal class and power relations. According to Huber (2000), who linked power and leadership within a nursing context, power and leadership are intimately intertwined as
power is also the ability to exert influence over others. Burns’ (1978) classic work on transformational and transactional leadership, which is often highly regarded and utilised as a framework for nursing research, espouses that “naked [italics added] power wielding can be neither transactional nor transforming, only leadership can be” (pp. 19-20).

Managing meaning and constructing leadership—It’s only make believe
Handy (1994) acclaimed that successful organisations required leadership of ideas. Similarly, Girvin (1998) noted that “transformational leadership concentrates on the ability to influence situations or people by affecting their ways of thinking, even affecting their underlying values” (p. 38). Congruent to this and within the nursing literature, Dye (2000) asserted “perception is more important than reality because people will believe only what they imagine to be true rather than believe the actual truth. As a people orientated leader, your job is to steer others’ way of thinking” (p. 55). The notion of leadership as the ability to influence others, promotion of a vision, use of charisma, and the ability to motivate followers through communication may be aligned with the concept of the management of meaning (Hosking & Morley, 1988; Huber, 2000; Smircich & Morgan, 1982). Dunford (1992) similarly described managing in nursing as

vitaly concerned with the management of meaning; that is, the construction and perpetuation of a notion of ‘why we are all here, what we do and how we do it’.... The core activity of management is seen as making what is going on in the organisation meaningful. (p. 23)

Grint (1995) similarly attested that what management really is arises from how it is constructed through the accounts of various agents involved. Grey (1999) furthered this notion in stating that the shifting meanings attached to management reflect the contestations around the social construction of management so that there are competing claims about what management is and should be. Management activity is therefore prone to fads and fashions as different ideas are contested on a fractional and incohesive knowledge base (Abrahamson & Fairchild, 1999).

Hosking and Morley (1988) defined leadership as a special kind of organising activity contending that what is important is the process by which particular acts come to be perceived as contributions to social order and therefore come to be perceived as leadership acts. Leaders construct more or less stable social orders, which in turn more or less are effective in protecting and promoting values and power relations. Calás and Smircich (1988), in examining practices of writing about leadership in the literature, argued that we have created or made leadership as much as we do leadership. The rules of science, which have governed the development of leadership knowledge, and the stories that can be told about leadership have excluded many alternate perspectives. Dachler (1988) also argued that
“established knowledge of leadership is not an objective value-free known reality. It is a reflection of what leadership research as a discipline in the context of western cultures has constructed as its reality, which is but one of many possible leadership realities” (p. 265). Dachler contended that traditionally realist and empirical root assumptions have been utilised, rather than viewing management and leadership as a product of complex social relationships. Notions such as charismatic and transformational leadership have more to do with how charisma is constructed in the context of a particular setting and its cultural understanding than with any possession, property, or natural trait. Dachler further contended “charisma is a relational concept and the leader is part of a social construction process of the followers’ reality ... [by which the leader] is interpreted as being charismatic” (p. 275).

Language is used by leaders to give meaning to work with metaphors and political language utilised to influence and motivate workers (Henry & LeClair, 1987: Huber, 2000). Bennis and Nanus (1985) aligned this with being a social architect. Language, including informal gossip, has a strong effect on the socialisation of woman and nurses (Duff, 1993; Laing, 1993). Language, according to Pondy (1978), is a key tool of social influence. Pfeffer (1981) depicted how increased work and productivity could be achieved with little resistance as long as the changes instigated were performed under the useful and assumed potentially achievable goal, language, and guise of meeting worker needs.

Current leadership literature can be viewed to reflect a more sophisticated method of managing meaning and attempting to motivate staff toward organisational goals through articulated and promoted visions and values rather than coercion. This has extended to include such elements as spiritual and emotional intelligence, and the creation of soulful workplaces (Cadman & Brewer, 2001; Dye, 2000; Goleman, 1998; Izzo & Klein, 1998; Weisinger, 1998) where the skilled management of emotions and worker energy is tapped. Cousins (1987) noted “management must allow some degree of autonomy so that the creative potential of that workforce can be utilised in production” (p. 39). Older theories of leadership are frequently chastised in the literature with new theories espousing improved work performance and effectiveness. Values and visions, communication, and participation have replaced styles, traits, and contingencies. However, achievement of organisational goals remains consistent and the first priority with recognition that the relationship and social meaning between leader and follower as it appears, especially to the follower, requires careful management.

Pfeffer (1977) described leadership as “associated with a set of myths reinforcing a social construction of meaning which legitimates leadership role occupants, [and] provides belief in potential mobility for those not in leadership roles, thereby providing a belief in the effectiveness of individual control” (p. 112). Laurent (1978) similarly described leadership
as a cultural value and stated “domination, under its socially acceptable form of leadership, is the prevalent cultural value among management practitioners, researchers and educators” (p. 227). Perhaps less caviling is a dialectical view of leadership that views leadership as a social construction of reality, which involves ongoing interaction of at least two points of reference, that is, of leaders and of the led with continual transformation of the relationship (Smircich & Morgan, 1982). This view is an ongoing flowing process rather than static, and affords human agency to all members of an organisation with leaders becoming followers and followers becoming leaders in different organisational interactions. Furthermore, leadership literature has depicted leaders as controlling the construction of reality for subordinates through a monologue or one-way street with the assumption of superiority and control rather than a social process of negotiation. This is often depicted in the requirement, obligation, and apparent ease for creation of an organisational culture (Sovie, 1993). Viewing leadership as episodic rather than continuous is also supported by Armstrong (1992) and the research of Rost (1994). Nursing literature could not be identified with this notion and instead has depicted managers or leaders as responsible for organisational culture and leadership.

The focus of this study is primarily on the concept of management, that being the formal designation of a management role within an organisation. However, literature pertaining to nursing administration and leadership is also included where appropriate due to the interchangeable use by many authors, the areas of overlap, and the seemingly evolutionary nature of the terms. According to Dilenschneider (1992), the terms have represented similar concepts of power within a changing and evolving discourse with power as administration in the 1950s and 1960s, power as management in the 1970s and 1980s, and power as leadership in the 1990s. Feldman (2001) argued “a shift in focus from administration to management to leadership has evolved to meet the needs of highly complex institutional settings” (p. 27). This, however, depicts the relatively uncritical stance that is seen in most of the nursing literature pertaining to management and leadership and the tendency of nursing literature to adopt dominant discourses and place leadership upon a pedestal. The following component of the literature review focuses on discussing the organisational discourses that frame the study of management and identifies specific nursing studies within organisations where they have been conducted.

Organisational discourses of management—Men at work
A nurse manager, as defined by the American Organization of Nurse Executives (AONE) (1992), is a registered nurse holding 24-hour accountability for the management of a unit(s) or area(s) within a health care institution. This definition notes the designation of a formal
position and further identifies the roles of the nurse manager to include managing the human, fiscal, and other resources necessary to manage clinical nursing practice and client care. The National Health and Medical Research Council (1991) has defined the role of the nurse manager within Australia that lists responsibilities for managing staff and resources similar to that of AONE (1992). The role is noted to be complex, encompasses multiple responsibilities and is depicted to comprise a list of traditional management functions including planning, organising and controlling.

Management can be defined as a function, a set of activities … the carrying out of tasks through other people…. These conventional, universal statements of what management is about and what managers do—planning, organizing, coordinating and controlling—do not tell us very much about the organizational reality, which is often messy, ambiguous, fragmented and political.

(Alvesson & Deetz, 2000, pp. 5-6)

Whilst much of the traditional organisational literature is normative and depicts the concept of management as static, rational, functional, purposeful, and formal (Parsons, 1964; Peters & Waterman, 1990; Taylor, 1990; Weber, 1964), critical and postmodern perspectives depict management as a social process that is fluid, socially negotiated, and highly political (Alvesson & Deetz, 2000; Alvesson & Karreman, 2000; Dachler, 1988; Georgiou, 1973; Hassard & Parker, 1993, 1994; Jones & May, 1997; Mintzberg,1983; Starratt, 1993). Sjöstrand (1997) noted a dualism between management, theory, and practice which he asserted “is a consequence of the fact that the major parts of management science have been founded on normative idealistic theories (sometimes even ideologies), rather than on theories relating to empirical studies of actual managerial practices” (p. 41). Vaill (1991) also argued that the myths of management regarding control and rationality are unfounded.

Mintzberg (1990), in one of his seminal works researching managers by direct participant observation, noted that managers spend very little time doing what they are said to do and that a manager’s job is characterised by pace, interruptions, brevity, variety, and fragmentation of activities, and a preference for verbal contacts. Pugh and Hickson (1989) contended that “managers spend a considerable amount of time in scheduled meetings and in networks of contacts outside of meetings” (p. 32). Kirsch (1988) also found that managers spent up to 80% of their time interacting with people rather than the performance of functions in isolation behind closed doors. Krass (1997) noted that leaders preferred oral media to aggregated information and that they relied on personal contacts and informal relationships, utilising formal sources and processes only to document or substantiate what was already known. Grove (1997) identified that the most useful information to managers came from quick casual conversational exchanges, many of them on the telephone. Baxter (1993) identified self-perceptions of nurse managers that their activities were frequently
unstructured, reactive, and informal. This has been further supported by research that reports nurse managers as often relying on informal knowledge and making decisions based upon common sense rather than empirical evidence (Bryan-Brown & Dracup, 1998; Kirsch, 1988). Young, Peden-McAlpine and Kovan (2001), in a hermeneutic study of 10 senior nurse executives nominated by nurse experts as transformational leaders, also found nonlinear inductive, rather than deductive and intuitive decision making, to be reported by nurses involving time and presence to gain organisational understanding. Intuition, muddling through, and viewing management as an art form are important current competencies of managers (Davidhizar, 1991; Muller-Smith, 1995; Vaill, 1991). Specific discourses of management are now further explored.

**Normative and positivistic notions of management as technical, functional, scientific, and rational—The age of reason**

Most of the organisational and management research has focused on workers as subjects rather than managers, including the classic studies of Herzberg (1966), Mayo (1990), and McGregor (1990). Few studies have included direct participant observation of managers (Horne & Lupton, 1965; Irurita, 1994; Keller, 1991; Kotter, 1990; Mintzberg, 1994; Pfeffer & Salancik, 1977). However, those that have been conducted support the finding of Mintzberg (1990). Despite this research, much organisational and management literature continues to depict organisations and the work and function of managers as rational, scientific, formal, and as conducted in semi-isolation, including the reading and writing of extensive reports, the formulation of budgets, and the construction of extensive organisational plans, systems, and protocols.

This normative representation of the work of managers exists particularly in nursing management texts where the major topics include, managing and leading, delegation, time management, budgeting, coordinating, motivating, change management, staffing, and scheduling (Clark & Copcutt, 1997; Grossman & Valiga, 2000; Huber, 2000; Marriner-Tomey, 2004; Sullivan & Decker, 2001; Tappan et al., 2001; Yoder-Wise, 2003). The normative positions are overtly apparent in older texts. La Monica (1983) advocated that a scientific method and approach is required for nursing management “as it forces the manager to plan, organize, motivate and control logically and analytically. Further, it allows the manager to build contingency plans for all possible outcomes” (pp. 1-2). In 1973, this scientification and reification of organisations and management was noted.

Organizational analysts have been unable to cope with the reality of organizations because their vision is monopolized by an image of the organization as a whole: an entity … so superior that it is effectively divorced from the influence of the parts …. not as the product of interaction between the
parts, but as determining them. The organization is endowed with a personality while the individuals constituting it are depersonalised.

(Georgiou, 1973, p. 299)

Jones and May (1997) disputed the notion of effectiveness in human service organisations noting that, central though the concept may appear, there is not universal agreement about what it means. It can mean meeting the stated organisational objectives or goals assuming that they are unambiguous, it can be equated with organisational survival and growth, or it can be held to mean meeting workers, managers, or any other social or consumer views including such things as doing valuable work.

There cannot be a final, unambiguous definitive, scientific statement about the effectiveness of a human service organisation or programme. All assessments of effectiveness reflect the values and interests of those undertaking the assessment and are open to varying interpretations … while often involving research and other technical processes [it] is inherently a political contest.

(Jones & May, 1997, p. 393)

New (1999), in an analysis of values within the NHS, identified conflicts and contradictions that health managers negotiate advocating that these conflicts which require trade-offs should be honestly explicated rather than managers be caught in the inevitable process of not being able to live up to unrealistic ideals. New (1999) listed a series of pairings of these values, which were choice versus equity, equity versus efficiency, democracy versus equity, efficiency versus democracy, and efficiency versus universalism.

Traditional discourses of management and organisations therefore primarily reflect normative based notions of scientism and rationality, whilst the few more critical approaches adopt discourses of social negotiation. Research regarding required changes to health care organisations have recommended engineering, re-engineering, beyond re-engineering, and corporate restructuring of such things as the business of healthcare or the intelligent organisation (Brown, 1994; Hammer, 1996; Kleinke, 1998; Smith & Flarey, 1999). Current nursing management texts adhere to the positivistic and normative discourse of scientism and rationality. Marquis and Huston (2003), in a relatively recent nursing management text, argued for a small authority-power gap in order to prevent chaos and ensure productivity as the organisation should rightfully expect that its goals are accomplished. Furthermore, “the core dynamics of civilization are that there will be a few authority figures pushing the many for a certain standard of performance” (p. 189).

Most nursing management texts are based upon the opinion and past experience of the author taking a very prescriptive stance towards how a nurse should successfully manage or lead (Andersen, 1999; Bernhard & Walsh, 1995; Clark & Copcutt, 1997; Cuthbert et al., 1992;
Dye, 2000; Fagin, 2000; Girvin, 1998; Grant & Massey, 1999; Marquis & Huston, 2003; Marriner Tomy, 2004; Sullivan & Decker, 2001; Tappen et al., 2001; Yoder-Wise, 2003). Few texts incorporate or support their assertions with any significant scholarly literature or research (Bower, 2000, Hein & Nicholson, 1994; Huber, 2000; Schorr & Zimmerman, 1988). This is similar to the findings of Hiraki (1992) in an analysis of nursing texts and Huntington and Gilmour (2000) who utilised a postmodern feminist perspective to review fundamental nursing texts important in the enculturation of nursing students. They both found that knowledge that was privileged within the texts was that of medicine. Within nursing management texts, research is often added on to traditional management topics similar to how research was found organised by Apple and Christian-Smith (1991) in an analysis of core undergraduate nursing texts.

Davies (1980), in reviewing nursing history literature, noted that the history of nursing focuses on leaders and achievements as it presents a celebratory account of advance from out of the dark ages to the modern times. This so-called reform or progress can be aligned more with change as influenced by the discourses of dominant interests (Herdman, 1998). Those who provided the nursing care were largely ignored (Dingwall, Rafferty & Webster, 1988) and their experiences were largely unaccounted (Herdman, 1998) as the unordinary and exceptional commanded fascination over the seemingly unimportant work that nurses performed on the job (McPherson, 1996). The privileging of accounts of senior nurse managers may also be attributed to the historical differences in social class between nurse administrators and nurses whereby the criteria for appointment as a nurse executive included social status and acceptance by male administrators and doctors (Godden, 1995). Literature documenting the experiences of nurses is usually of high profile individuals utilising interviews or an autobiographical format to depict their experiences and lives (Schorr & Zimmerman, 1988; Scutt, 1992; Smith, 2002).

Nursing literature on management and leadership is replete with strategies for how a nurse should become a successful nurse manager and leader (Bower, 2000; Feldman, 2001; Yoder-Wise, 2003). According to Edwards and Ribbens (1991), the term strategy is used to explain actions of individuals who are rational and therefore legitimate and unopposable and that this term is derived from public realm ideologies, male dominated spheres of activity, and public institutional values and norms of self-presentation.

In line with the discourse of science and rationality, the relationship between managers and non-managers is usually assumed to be unproblematic and easily categorised or classified into two bipolar categories: managers and workers. However, Alvesson and Deetz (2000) noted that the relationship between managers and non-managers is not clear-cut as managers also work, they do things, and workers manage in the sense that they plan, decide, solve
problems, coordinate, take initiatives, and exercise influence. This dichotomy apparent in the literature is important in the context of this study, particularly within nursing as many nurses, including the participants of this study, are simultaneously in the position of both managing other nurses and still workers or being managed. Even the most senior nursing positions may be defined as workers and are accountable to a further level of management. Few nursing management texts, with the exception of Kirsch (1988), Yoder-Wise (2003) and Sullivan and Decker (2001), acknowledge this fluidity of roles.

With the exception of Sullivan and Decker (2001), there is an absence of literature that examines the relationship of nurse managers with further levels of management or nurse management. Inherent in most nursing management texts is the instructional requirement for nurses and nurse managers to be submissive. Sullivan and Decker prescribe strategies for nurse managers in dealing with superiors that include giving immediate positive feedback to the supervisor, tactfully filling in and finding ways to compensate for their weaknesses, volunteering to do things the supervisor does not like doing, and establishing a positive relationship with the supervisor’s secretary. According to Sullivan and Decker, the nurse managers should “understand that a supervisor is a person with even more pressure and responsibility” (p. 180). Kirsch (1988) drew attention to the fact that leadership skill requirements may be different at differing levels of nursing positions rather than just adopting the frequently utilised discourse of the generic successful nurse leader. Lawler (1991b) has described how the discipline of nursing dominated by North American discourse has embraced “positivist scientific models, and with them reduction, objectification, quantification and taxonomic linear thinking. We have been encouraged to see scientific knowledge and scientific nursing practices as universal and highly desirable features of the discipline” (p. 214). Similarly, Hewison and Stanton (2002) in an analysis of the development of nursing and management theory noted that nursing has uncritically accepted and implemented many ideologies resulting in imposed notions such as care plans and the nursing process with little prior critique of their benefit.

Marginalised and critical discourses of management—*I hear a symphony*

Similar to the dialectical view of leadership advocated by Smircich and Morgan (1982), Alvesson and Deetz (2000) have viewed the concept of management as a social construction. Alvesson and Willmott (1992) noted that the study of management has been almost entirely devoted to the study of the scientific improvement and function of management with assumptions of efficiency and effectiveness and managers portrayed as rational, purposeful, and carriers of initiative, whilst workers are depicted as being passive and objects of managerial action. Furthermore, the positivistic perspective of management portrays it as a socially valuable technical function working in the interests of all alike. Critical perspectives
view organisations as political arenas with no goals of their own but as “arbitrary focuses of interests [and] market places whose structures and processes are the outcomes of the complex accommodations made by actors exchanging a variety of incentives and pursing a diversity of goals” (Georgiou, 1973, p. 291). Dunford (1992) similarly argued that the “so-called ‘goal’ of the organisation is not something which clearly and unambiguously exists” (p. 24).

Critical perspectives question the neutrality or virtue of management as self-evident or unproblematic and are concerned with the lives of employees, managers, consumers, and citizens. They also allow for the analysis of managerial discourse and practice in terms of voices that speak loudly, but also those that are marginalised, including feminist voices, which have only recently been heard in the management literature (Alvesson & Willmott, 1992). Critical perspectives of organisations and management are far more limited in number than those that uphold scientific and positivistic perspectives, however, they have included the research of disciplinary power within institutions that shapes identity and leads to undemocratic public decision making (Deetz, 1992b), power and action in communicative practices shaping relationships (Forester, 1992), and differing perspectives of pleasure contesting that traditional views such as Peters’ (1997) attempts to channel creative energy into the organisation by attempting to unlock some pleasure at work (Burrell, 1992).

Other critical studies have advocated that organisations construct sexuality and that dialectically sexuality constructs organisations such that sexuality and organisational life that are frequently artificially divided can be described as one social process (Hearn & Parkin, 1987). Social work in health care (Jones & May, 1997), information systems (Lyytinen, 1992), and the discourse of marketing (Morgan, 1992), have been studied within organisations utilising critical perspectives. Nord and Jermier (1992), also utilising a critical perspective, found that managers themselves were frequently subordinated and oppressed by other groups and that intra group subordination also occurred.

In one of the few critical studies of the organisation of nurses, Chau (1989) researched the tensions embedded in the management and control of nurse expertise. Drawing on historical documentation of nurse training and registration in Britain and utilising direct observation of nursing care within two hospitals, he traced the development of the occupation to gain professional status. Chau argued that registration and training were instigated by an elite group of upper class nurses (the matrons and administrators) to restrict occupational entry only to individuals who emanated from a relatively well-educated class background. Creating a second level of nurse and ancillaries allowed for the relegation of the direct-contact tasks of nursing to inferior nurses who had no career structure in management, whilst the skills of the registered nurse, he observed, were emphasised to be decision making, care-
planning, coordination of tasks, overseeing, and surveillance of the subordinate practical nurse. Chau argued that with the rise of managerialism a hierarchical, pyramid type administrative career structure arose with administrators afforded higher pay whilst clinical nurses remained without a career structure. The skill of administration has been elevated “at the expense of ‘basic nursing’ … [and] if the greater expertise of a sister or a senior nursing officer is in administration what difference is there between a nurse and an administrator?” (p. 205). Chau further asserted that whilst this contradiction is unlikely to be widely publicised, it undermines internal cohesion and solidarity.

Several articles caution that the concept of empowerment has become transformed or metamorphosed from the vocabulary of reform and social movements expressing conceptions of inequality and oppression into the competing discourses and ideology of management (Clarke & Newman, 1997; Collins, D., 2000; Kuokkanen & Leino-Kilpi, 2001; Mintzberg, 1996). Within many management studies empowerment is defined as the ability to get things done and measured by increased productivity and organisational effectiveness (Laschinger, 1996). Buzzwords such as total quality management and the wide range of practices that can be implemented under the rubric of empowerment can disempower by reinforcing the hierarchy, whereas true empowerment results from power being built into the work of employees (Mintzberg, 1996). Discourses of empowerment may not, therefore, have a critical intent, and management practices that espouse empowerment should be critically analysed before being introduced (Hewison & Stanton, 2003).

**Management as a discourse of managerialism—*Pomp and Circumstance March No. 1***

Managerialist discourse has been described by Deetz (1992b) who identified managerialism as

a way of conceptualizing, reasoning through, and discussing events … that entails a set of routine practices, real structures of rewards, and a code of representation. It is a way of doing and being in corporations that partially structures all groups and conflicts with, and at times suppresses, each group’s other modes of thinking …. As a set of discursive moves [it] interpellates a particular type of subject and produces a particular world. (p. 222)

Managerialist discourses within organisations have similarly been described by Scott (1985), Ingersoll and Adams (1986), and Alvesson (1987). Deetz (1992b), combining some Foucauldian notions with a critical perspective, depicted the corporate institution as the powerful central modern institution rather than the state or church, and asserted that it undemocratically directed decisions and affected quality of life and the contemporary production of meaning by colonising perceptions, thoughts, feelings, and actions. Furthermore, Deetz contended that “with managerialism, certain interests are arbitrarily
privileged, the process of reaching decisions is distorted, and meaningful conflicts are suppressed” (p. 5).

Central features of managerialism include an imaginary unitary identification with the corporation and management, and a primary mode of reasoning that is cognitive-instrumental. Economic growth is thought to be the main goal of society with business and technical development seen as a measure of progress. Hierarchical social relations distinguish between the leaders and the led which is thought to be natural rather than socially constructed (Alvesson 1987; Deetz, 1992b). Workers, managers, and unions all speak and act in normative accordance within this discursive space of managerialism. Deetz (1992b) argued that “fear is not of an authority oppressor, but that one’s own self will not behave and conform … [as] teamwork, worker participation programs, and the management of culture become important modern means of control and conflict suppression” (pp. 321-322). Deetz further argued that there is a space for agency and choosing sometimes to explicitly reject a move within the prescribed game and choosing to fail or to play another game can resist managerialism in everyday activities. Jones and May (1997) described prevalent new terms in human service organisations within the discourse of managerialism including mission statements, corporate and strategic planning, efficiency and effectiveness auditing, targeting, programme budgeting, performance indicators, quality assurance, and program evaluation. They asserted that the skills required to manage human services are now viewed to be those of content-free-management and stated “a record of involvement in, knowledge of and commitment to a field of service is viewed as of secondary importance, or even as a liability. These developments serve to increase the influence of managers and managerialism” (p. 389). The commodification of care and attempt to control products of care has been identified in discourses of corporate language within hospitals, including clinical pathways (Georges & McGuire, 2004), and case management (Padgett, 1998).

Carpenter (1977) in examining nursing management in the UK, identified that nursing service managers sought to professionalise through business administration strategies rather than through their nursing skills. This has more recently been supported by Hewison and Wildman (1996) who further argued that the emphasis within health care on efficiency, effectiveness, and economy has widened the theory practice gap for nurses as the values embedded in nurse education of individualised care, humanism, and holism are markedly divergent. More recently Hau (2004), in an ethnographic study of three wards within a hospital in Singapore, identified a strong pervasive managerial discourse that preoccupied nurses with classifying patients, freeing-up bed spaces, and the efficient and economic government of beds. Hau concluded that managerial discourse colonised the minds and working lives of clinical staff to “sing the same tune” (p. 6). Rather than overt authority
managerialist discourse, together with modernist notions of holistic care, developed in nurses’ subjectivities that were self-regulating and self-tasking. Similar to the results of a study of community healthcare workers (Brown & Crawford, 2003), Hau contended that nurses may have sufficiently absorbed the care discourse to construct a way of driving themselves on within a managerial context.

Management as empowering and shared relationships—Beautiful noise

More recent management and organisational literature has advocated for reducing the rigid, functional, and impersonal hierarchical management styles within organisations (Alderston & McDonnell, 1994; Champy, 1995; Hammer 1996), and for adopting relationships and styles of management that empower employees as well as providing respect, reward, and dignity for employees. Senge (1990) and Greenleaf (1998) advocated for servant leadership, being participation in the leadership role and decision making by consensus, similar to the model of leadership recommended by Block (1996) who utilised the term stewardship. Block and Greenleaf, akin to Duignan and Bhindi (1997), advocated authentic leadership based upon allegiance and trusting relationships that move away from the conventional coercive paradigm of strong leadership and people using to people building. Emotionally intelligent leaders who can empathise, resonate, connect, sense how others feel, and create cohesion are important (Goleman, Boyatzis & McKee, 2002), as well as leaders who treat all people with respect and as equals (Sample, 2002). Kouzes and Posner (1999) argued that effective leadership is truly caring for people, the ability to show and truly feel warmth, and fondness towards others. Emotional intelligence, transformational leadership, leading with soul and spirit are contemporary popular leadership concepts, however, they are still often guided by the principle of increasing economic productivity and also predominantly authored by men (Elliot, 2002; Goleman, 1998; Hede, 2002; Sarros, 2002). Whilst highlighting the importance of emotions they often, however, include tools for managing emotional reactivity in self and others and how best to recognise and optimise the emotional state of others.

Mintzberg (1997) described the organisational culture of hospitals as unhealthy and unhappy and recommended a humanistic change to this culture. Weiss (1995) and Cloke and Goldsmith (1997) have advocated for what they term an empowered environment or culture. Similarly, a learning environment and personal responsibility (Alderston & McDonnell, 1994), decentralised decision making and flexibility (Acorn, Ratner & Crawford, 1997; Liedtke & Whitten, 1998), the sharing of information and power (Schneider & Bowen, 1995), and a sense of community (Izzo & Klein, 1998), are all recently attested to be requirements of successful organisations. Bower (2000) aligned an empowered culture with shared governance and asserted that many top firms have moved to this model whilst the health care environment has been slow to adopt the concept. Environments to empower
nurses was explored by Chandler (1991) who, drawing upon the work of Kanter (1977), surveyed 247 registered nurses identifying a lack of appropriate support, information, and opportunity.

Peters (1994) identified three areas of competence of successful companies denoting one competency to be a belief in the dignity, worth, and value of every person in the organisation. The other two competencies he identified were superior customer service and internal entrepreneurship. Whilst the first competency is highly applaudable, the potential conflict inherent in these competencies of valuing employees and yet creating profit (entrepreneurship), whilst highly evident, is rarely discussed. Morris (1997) advocated that successful organisations will simultaneously meet the demands of the market place and the inner needs of the workplace. The argument emanates from increased productivity attributed to efficient and happy motivated workers reminiscent of Herzberg’s (1966) now dated motivation-hygiene theory. Whilst Peters’ model is more sophisticated and recognises issues of chaos and uncertainty, the balance between the competing competencies is not explicated or defined. The desires, motivations, and pleasures of workers are considered only in respect to economic productivity and as defined, managed, or visioned by management. Larger social issues such as the environment remain unattended.

A stakeholder model of management within health care has been advocated by Gilmartin (2001) and Malloch, Sluyter, and Moore (2000) who claimed it celebrates the human condition, that exemplary service is cultivated, and human caring becomes an enterprise-wide value. Similar to Freeman (2004) and the feminist adaptation and reinterpretation of this model by Wicks, Gilbert, and Freeman (1994), Gilmartin advocated this stakeholder model to counter the dominant stockholder model that confine management activities to those related to profit generation and economic viability. This model instead views business enterprise to consider the role of value creation and social responsibility by considering the interests of groups that can affect and are effected by the action of the organisation including suppliers, customers, employees, financiers, and communities. Feminist interpretations stress that organisational governance should involve the principles of caring, connection, and relationship (Malloch et al., 2000; Wicks et al., 1994). Stakeholder relationships support the coalescence of human connection for nursing and foster collegial relations among professionals. Malloch and Porter O’Grady (1999) similarly proposed a partnership economic model, which is again based upon social responsibility and support for ethical and caring human relations.

Transformational leadership, as depicted by Bass (1990), is more frequently practiced by women and nurse executives than men in management positions (Dunham & Klaufhn, 1990; Rosener, 1990; Sarros, Gray & Densten, 2001). Transformational leadership has been
described by Dunham-Taylor and Klafehn (1996) as a style of leadership with charisma that communicates a vision and values to staff, provides individualised consideration of staff members, empowers them to be all they can, and provides intellectual stimulation. Holter (2002) described her interpretation and application of transformational leadership within nursing in a 480-bed teaching hospital in Oslo.

Important for transformational leadership is that you have individual consideration …. It’s that mutual relationship there, it has to go both ways … you have to get out of an autocratic role. You have to really be there, to empower others, and you do that by giving, by creating an atmosphere so that we can learn from each other. We are not there to be above someone else … we need nurses to have that potential [to grow] and people who nurture them to whatever their potential is … we have no nursing retention problems.

(Holter, 2002, p. 36-38)

Some studies have also attributed transformational leadership to improved effectiveness and financial performance (Bass & Avolio, 1993; Kouzes & Posner, 1999), and in nursing leadership effectiveness, extra staff effort, and improved staff satisfaction (Bowles & Bowles, 2000; Dunham, 1989; Dunham & Klafehn, 1990; Dunham-Taylor & Klafehn, 1995; Holter, 2002; Marks-Maran, 1999; Storude, Vandenbergh & D’hoore, 2000). One Swedish study that surveyed 23 nurse managers, however, contradicted the notion that transformational leadership was related to increased organisational effectiveness (Prenkert & Ehnfors, 1997). Storude et al. also found the hospital’s culture and structure were major determinants of leadership styles rather than a cascading effect of transformational leadership from senior leaders. Dunham-Taylor and Klafehn (1996) further asserted that nurse executives often have difficulty implementing transformational leadership as they usually report to male bosses who frequently have a more transactional style of management. Whilst there is a wide range of styles and modes of leadership and management within nursing that advocate to be transformational leadership, they often concentrate on style and structure rather than values. Transformational leadership has also been aligned with non-Western world views and has been based on valuing others, nature and the ecosystem, and on the uniqueness of individuals contributing through self, connecting with the potential of other human beings, and in being one with the universe (Koerner & Bunkers, 1994).

“The hallmark of transformation is a change at the deepest level of the social structure” (Koerner & Bunkers, 1994 p. 71), including the basic assumptions about who we are, what kind of universe we live in, and what is ultimately important to us. Drawing on a Native American notion of each person being an expert of their own process rather than the Western scientific highly specialised and isolated expert, they advocated that each individual adds a unique contribution to the whole, making community essential to a holistic view of current
reality. Anderson and Hopkins (1992) noted that nurses have been socialised into believing that the expert is someone outside of themselves. They stated “we must listen to the deep source of wisdom within ourselves and tell the truth about our lives and what we are learning … questioning everything we have been taught or taken for granted … not validated by our own experience” (p. 7).

This has been similarly expressed by Koerner and Bunkers (1994)

[for] experiencing true community within the profession calls for a unique way of communicating, sharing our deepest thoughts and feelings without fear or guilt. Through an increased awareness in unconscious assumptions, which influence and control attitudes and beliefs, we are free to overcome prejudices, transcend our differences and learn to accept and love ourselves and each other. (pp. 78-79)

Hartrick (1997) proposed a model of human relating that reflected humanistic values and challenged the mechanistic behavioural models of human relating dominant in nursing. The model included the capacity for initiative, authenticity and responsiveness, mutuality and synchrony, honouring complexity and ambiguity, intentionality in relating, and re-imagining. Whilst the model is advocated in respect to client care, the model is of human relations and caring relational practice that could be applicable in nurse management relations.

Other studies have recommended and demonstrated case studies of caring programs (Ameigh & Billet, 1992), and caring leadership (Brandt, 1994; Morath & Manthley, 1993), describing the nurse administrator as providing leadership for care by reflecting the values of caring through who they are personally themselves. With caring leadership, the nurse administrator provides the model for caring which is patient-centered, demonstrates care for colleagues, supports strategies for caring, respects and values all individuals, and facilitates communities of concern for care delivery. Watson (2000) described leading via caring-healing as an inner transformative path for leadership that combined elements of caring and healing energy with a spiritual, transformative journey to ensure nursing is sustained in the future and to better humankind.

Armstrong (1992) advocated managing by *storying around*, basing the model on having fun and re-establishing teamwork and trust between employees and employers. Kirkpatrick, Spickerman, Edwards, and Kirkpatrick (2001) also argued for storytelling as an effective way to promote and transmit a culture of healing and humanistic behaviour. Armstrong relayed the story of geese flying in a $V$ formation such that when the lead bird tired it rotated back in the wing and another goose flew point. When a goose was hurt or fell out, two geese fell out of formation to follow and protect the goose. By collectively flying in a $V$ formation, the whole flock increased its flying capacity. Whilst most notions of leadership espouse that
it does not require a formal position and that it can appear in various levels of an organisation, rarely is it suggested to be a transient, shared, or a rotated endeavour, with the exception of a feminist model contended by Wheeler and Chinn (1989).

Trust is often described as an essential component to the social relations within an organisation developing between people over time and through experience (Malloch, 2002). Trust in management by employees that follows from commitment practices rather than control practices has been established to correlate positively with organisational commitment and increased effectiveness (Whitener, 2001). Malloch (2000, 2002) surveyed perceptions of trust of 612 employees within three healthcare organisations within the US who had commenced efforts to transform their organisations into having cultures of healing. Cultures of healing were described as ones in which trust, continuous learning, compassionate and nurturing behaviours were valued, and which ultimately led to improved patient outcomes, community reputation, staff retention, and profitability. Mulloch (2002) claimed that in each organisation healing behaviours scored high and that the perception of trusting behaviours were highest in the organisations who had implemented the healing changes the longest (eight years and six years). Wesorick (1996, 2002) also advocated for healing environments, drawing on data gathered in the last 18 years from the Clinical Practice Model Resource Center in the US. She concluded, similar to Walker J. (1994) and Kerfoot and Newman (1992) that managers need to create and sustain healthy, healing work cultures. Balancing polarities, adopting new ways of relating that include genuine dialogue and meaningful conversation essential to ensure mutuality, and consciously valuing relationships that foster dignity and respect are key requirements of a healthy work culture. Similarly, Brown (2002) advocated for building trust in relationships to empower nurses based on recognition and support of their full worth as human beings. Brown further argued that emotions, which have traditionally been neglected, are integral to all relationships.

Alternate perceptions of trust, however, are also evident in the literature. Gilbert (1998) noted that nursing literature often depicts trust from a technical approach and fails to analyse relations of power. Gilbert argued that trust, rather than being a neutral and benevolent concept, is manufactured within social relationships, enabling particular opportunities to be created or excluded and resources to be claimed and distributed. Complex social systems establish specialised positions of trust which are not just given to individuals but require symbolic processes such as qualifications and promotion to exercise functional authority. To earn and maintain trust, systems must be conscious of their self-presentation, which may include strategically appearing personalised. Kinship has been substituted by formal organisation. Gilbert further argued that mistrust is essential to the promotion of trust and has a functional role in reassurance and in establishing guardians in the form of councils and
boards, which sanction symbolic processes. Professional education, mentoring, and credentialing ensure individuals are skilled in a range of strategies for impression management.

Wolf (1988), in an ethnographic study of nursing rituals including handover, medication administration, and post-mortem care in an acute care context, identified spiritual and sacred dimensions of nursing knowledge and practice that were primarily passed to other nurses via word of mouth. Critical methodologies were utilised by Manias (1998) and Street (1992) in clinical ethnographies respectively of nurse-doctor collaboration and clinical nursing practice. Street’s study, conducted within a large Victorian hospital, identified a strong oral culture, invisibility, and nurturance knowledge, as well as power knowledge, that existed in a hegemonic medically and bureaucratically dominated system. However, values of the clinical nursing culture and through which nurses identified in their personal and professional self-image as caring were evident. Manias’ study, conducted within a Victorian ICU, identified the absence of nurses’ voices, the subjugation of nursing knowledge, the role of go-between and medication expert played by the nurse, and the self-policing of nurses. Wicks (1995), in an Australian postmodern ethnography of nurses, distinguished discourses of healing constituted by nurses and doctors in their daily work. She revealed an alternate, oppositional knowledge and practice framework and, contrary to much of the literature, a generally unrecognised level of nurse autonomy in some areas. Wicks (1995) described both collegial and conflicting relations among nurses. Porter (1995) undertook a critical realist ethnography within an ICU in Ireland. He concluded that nurses frequently undertook informal decisions and strategies rather than formal modes in relations with medical staff and that medical staff found the informal and local knowledge of nurses often contested the power of their medical knowledge. Medical staff relied on legal structural support to maintain their dominant position in relation to nurses.

Instrumental patriarchal discourses of management—Playing with the boys
Management discourses, including those within health care and nursing, reflect androcentric values and mirror or adopt the patriarchal dominance evident in the larger social context. Within America, males have historically controlled public power and the implementing authoritative organisations (Duerst-Lahti & Kelly, 1995). Brown’s (1988) research also identified that politics and governance have historically been exclusively limited to men. Similarly, Jones (1993) asserted that this control of public authority has resulted in authority and legitimised power being more common for men. Duerst-Lahti and Kelly further argued that men’s domination of institutional power has enabled them to “create laws, legitimate particular knowledges, establish moral codes and shape culture in ways that perpetuate their power over women” (p. 20). As a result, when women enter and act within the realm of
leadership and governance they do so within the realms of masculine norms and within the normative constraints that gender modes impose encompassing the evaluation of behaviour and ways of being. However, whilst governance and leadership have been distinctively marked by men and masculinity, seldom have these concepts been acknowledged by scholars. Much of the scholarly work on leadership displays an absence of the notion of women and of gender (DiStefano, 1991; Duerst-Lahti & Kelly, 1995).

A study conducted by the American College of Healthcare Executives (1996), that surveyed nearly 100 senior health care executives, found that women health care executives experienced lower career attainment than men, and the gap between the two gender groups had grown over the last five years. Only 8% of the women in the study were chief executive officers, compared with 21% that were men. This survey also identified that women with similar levels of education and experience earned on average 16% less than their male counterparts. In this study, 90% of the participants noted that gender was an issue in their workplace. Robinson-Walker (1999), also in a study of healthcare leadership within the US, identified a continuing dearth of females in the most senior posts despite women comprising 85% of health care workers. Klenke (1996) found that women filled nearly a third of all management roles, but that the majority of the positions had relatively little power or authority. Foster (2001), like Carpenter (1977) and Briles (1994), found similar results in the NHS in Britain; that male managers outnumbered women managers by almost five to one.

Briles (1994) surveyed 300 healthcare workers, including nurses. Whilst, unsurprisingly for healthcare, females comprised 98% of the respondents, Briles identified a 34% increase in unethical behaviour by women toward women and what she termed sabotage, backstabbing, and undermining behaviour in the workplace compared to her previous study of the general workforce. Briles concluded that unethical behaviour is a power game and that both sexes behave unethically, although their styles and methods are different. She attributed her results to women having more opportunity to undermine other women when they are predominantly working with women and that if a woman is an aggressor she is more likely to direct her attention toward an individual who she perceives to have less power. Briles further concluded that women have to struggle hard to get ahead, that “women know these barriers are in place and may struggle even harder to get into the inner circles. If it means they have to push other women down to get there, that’s the breaks” (p. 35). As women occupy the lower status groups in an organisation, they are often the first to be terminated. The environment encourages women to undermine other women. She also noted that whilst these negative features existed, women simultaneously reported extensive and close personal friendships.
Ingrained gender roles and expectations are thought to contribute to the lack of women in senior management positions. Edwards and Lenz (1990) noted the difference in communication patterns between men and women asserting that, as gender is enacted in socialised roles, the problem for nursing “is not leadership ability, but the pervasive subtle perception that women are not leaders” (p. 51). Leadership itself is a term that is value-laden with aggression, competition, dominance, ambition, and decisiveness that is frequently associated with masculine traits and considered better (Klenke, 1996). LaBier (1986), in researching corporate careerists, identified that attitudes of toughness, aggressiveness and competitiveness, the ability to create a flurry of activity-meetings, memos and fire-fighting, the capacity to intimidate and humiliate others, and to get one’s enemies, were valued attributes in many organisations. He asserted that these pursuits, plus the emphasis and reward for pursuing power, grandiosity, and submission, are disguised as the standard of normalcy and commonly accepted as part of the job. Cognate with the previous research Calás and Smircich (1991), utilising post structural deconstruction and feminist notions, argued from their research that traditional patriarchal and positivistic modes of organisational research have imposed closure on what even can be said to be organisational knowledge.

Miller, J. (1997) similarly identified that feminine values of responsibility, connection, and inclusion are quite different from the traits of the competitive, rugged individual or lone hero model of leadership that has been traditionally revered. Noer (1997) described this hero model as the “macho, self-reliant, clearly differentiated good-guy” (p. 164). Gilligan’s (1999) research also concluded that women did not view the world in hierarchical terms but rather as a web of human connectedness, and from these webs they built relationships. Webs rather than pyramids are also described as a preference for women by Helgesen (1990), aligned with connective leadership (Lipman-Blumen, 1992). In a study of the culture of a Canadian hospital school of nursing, Valentine (1995) noted that the culture had an emphasis on workplace relationships and striving for interpersonal connection with food and social events facilitating and integrating relationships. Instructors tried to foster “more than just working relationships, they strove to be friends” (Valentine & McIntosh, 1990, p. 366). Spitzer (1997) also noted that women have been socialised to be people-orientated, expressing a desire to share resources, to serve as a resource and source of support to others, and that by facilitating success for others they are respected and consulted. This is often termed power with rather than power over. Held (1993) argued that discourses on relationships in public organisations all presume a contractual economic man model of relationships and this contractual notion provides no protection for the disadvantaged. Held advocated a mother-child model of relationships based upon a feminist morality with trust,
compassion, and a sense of shared community. In this model, there is also a shared concern for global effects and the environment and “the citizen becomes sister or friend” (p. 228).

Gender roles and expectations have been further highlighted by Spitzer (1997) who identified that nurses in emergency departments often reverted to learnt responses and were passive. Valentine (1995; 2001) and Cavanagh (1987) also noted that nurses avoided conflict and viewed conflict negatively, attempting to ameliorate conflict with homemade food and social events. Avoiding, compromising, and accommodating were the most frequent strategies of nurse and nurse managers to handle conflict rather than collaborating or competing. Several women participants in the study by Robinson-Walker (1999) also noted that because they were women they were brought up to be pleasers. A woman’s dedication had serious negative consequences for them as it translated into consistent hard work and the intensity, dedication, and long hours of senior management positions were personally felt. This was also noted in the American College of Health Care Executives’ (1996) study, which reported that women executives constantly felt the pressure to prove themselves. Furthermore, participants reported that women who did gain senior management positions often adopted what may be considered masculine leadership behaviours and could be more political, and more destructive than most men. Kirchmeyer and Bullin (1997), in a study of gender roles within nursing, identified that experienced nurses scored as high on the masculinity scale as they did on the femininity scale. High femininity was associated with little nursing experience, whilst high masculinity was a predictor of success in terms of pay. They concluded that feminine traits such as compassion and understanding may not yield financial rewards, nor help a nurse compete. Kanter’s (1977) research also supported this adoption of dominant masculine behaviours and attitudes, and identified concerns of equal opportunity, access, and equity for women in the workplace. Her further research identified that the observed behaviour of women in organisations (concern for relationships and being less assertive) was a function of their structural position (at the bottom) in a network of hierarchical relations rather than sex difference as men in similar low positions exhibited the same behaviour (Kanter, 1982). Ferguson (1984), in a feminist critique of bureaucracies, advocated for the transformation of bureaucracies and for women to develop their own ways of organising and leading rather than for women to gain higher positions within existing patriarchal bureaucracies. The embedded power and gender relations of male dominance and female subordination in organisations have also been noted in the work of Witz and Savage (1992).

Duerst-Lahti and Kelly (1995) found that gendered work roles were socially assigned and interpreted by senior executives. When a woman successfully entered into a leadership
position, it was interpreted as unusual, with a resultant heightened focus on the process of differentiation between the two assumed genders. The woman could either conform and display different traits then attributed to being female or she could do masculine leadership by performing leadership tasks in a way more masculine than men. Duerst-Lahti and Kelly concluded that all work roles, traits, and behaviours are viewed with a gendered lens such that there are no neutral leadership traits. Robinson-Walker (1999) noted in her study that women’s attitudes to acknowledging gender issues in health care management changed from strong acknowledgement when individually surveyed to denial when in a face-to-face situation and in the company of strangers, for the same participants.

Explanations for the paucity of female senior executives have alluded to further issues of gender, including that females are not as competitive as males and do not wish to pursue a promotion placing them above other women they work with Duff (1993), and that the cost of combining work and family is borne more heavily by women (Hochschild, 1989; Robinson-Walker, 1999; Rosener, 1995; Rozier, 1996). Rozier found male nurse executives’ salaries to be higher than females when adjusted for age, experience, and tenure, and female nurse executives still maintained responsibility for childcare when male executives were predominantly married with a non-working wife fulfilling that role. The American College of Healthcare Executives’ (1996) study and Capuzzalo, Bisognano, Gaucher, and Ryan (1995) attributed poor self-esteem and confidence in nurses as a significant factor in women not gaining more senior positions within health care. Robinson-Walker (1999) contended “the power and impact of the masculine model of leadership pervades” (p. 70), despite Borman and Biordi’s (1992) encouragement that female leadership skills and attributes were finally being recognised and essentially required within healthcare.

The expectation of women to buffer is also evident in literature of women senior managers. One of the unspoken rules of adult feminine behaviour is that women must buffer strife, which creates conflict for women between being nice and being selfish, and leads them to negotiate rather than claim (Borysenko, 1996). This buffering role has also been supported by Smith and Mitry (1994), specifically in respect to nursing leadership, and who advocated that it protected subordinates from external pressures, organisational forces, other supervisors, other employees, top administrators, themselves, and medical staff. Briles (1994), however, claimed that women managers can be over-controlling and manipulative due to their need to be aggressive and their constant feeling of being threatened with the difficulty in gaining and maintaining some control in a male dominated work environment. She argued that women have been trained to compete with other women for favoured positions with powerful men. Furthermore, and perhaps in contradiction, she asserted that women are socialised as girls not to compete and certainly that nice girls do not compete.
Briles noted “observers may view aggressive, successful women as saboteurs, whereas a man who behaved the same way would not be suspect” (p. 44).

Pringle (1988) and Tancred-Sheriff (1990), in critiquing values inherent in organisational discourses, highlighted the instrumental macho bounded rationality that prevails. Mumby and Putman (1992) concurred with this and alternatively advocated a form of organising that sustains values of nurturance, caring, communality, and supportiveness where the bonds between people are less instrumental, more enduring, and where there is an enhanced sense of community and care. This resonates with the work of Held (1993). Fineman (1994) identified rationalism, masculinism, and the marginalisation of emotions in discourses of organisation that suppress, deny, or minimise the role of emotions.

This has meant the perpetuation of a conception of organizing which often bears little resemblance to people’s experiential evidence .... To discount emotion is to remove the glue, which binds, and directs human conduct. If we lift the cloak of rationality there are other discoveries ... [as] people can determine what is emotionally correct for the enterprise forcing a harsh split between what people feel and what they can show they feel.

(Fineman, 1994, pp. 79-80)

Hochschild’s (1983) research depicted the roles and rules that were enacted by flight attendants but that the constant smiles often covered alternate emotions. Similarly, White’s (2003) research on intensive care nurses’ attitudes to brain death displayed how nurses portray a confident scientific type emotionless response in their work environment and yet individually and away from their colleagues they discussed emotional dilemmas and concerns regarding the issue. Ferguson’s (1984) research on bureaucracies discerned the difficulty of identifying alternate discourses, advocating that further feminist organisational research was required. Uris (1993) conducted one such study that explored nurses’ experience of moral madness in a variety of health care settings utilising critical, feminist, and postmodern theory. She found nurses explicitly accepted and uncritically maintained patriarchal ideology including such things as idolatry of the expert, individualistic autonomy, and support for the empirical-analytic knowledge paradigm. She concluded there was silencing of their caring by the oppressive patriarchal ideology which pressed nurses to doubt their caring as a way of being, knowing, and doing in the public realm.

Organisational discourses of managing identity and subjectivity—I am ... I said

The professional identity of nurses has been studies by Öhlén and Segesten (1998) who undertook a concept analysis incorporating an analysis of literature and interviews with eight Swedish nurses. In this study, nurses reported professional identity as an experience and as a feeling of being a nurse, as opposed to just working as a nurse. Personal identity was
connected to and preceded professional identity that developed over time and was shaped by education and interaction with colleagues. Whilst one participant in the study identified two images of a professional nurse, primarily the findings reflected one progressive linear-like process of image attainment. Similarly, Holland (1998), in a concept analysis of personal transformation, whilst noting the process not to be linear, defined it as “a dynamic uniquely individualized process of expanding consciousness whereby an individual becomes critically aware of old and new self-views and chooses to integrate these views into a [italics added] new self-definition” (p. 716). Both studies therefore sought the concept of an individual self.

Many postmodern analyses of organisation in health care institutions and organisations focus on the multiple realities and the construction of subjectivity and identity within these organisations. Clegg (1989) asserted

organizations should not be conceptualized as the phenomenological expression of some essential inner principle such as economic exploitation or rationality …. Organizational action is an indeterminate outcome of substantive struggles between different agencies: between people who deploy different resources; people who’s organizational identities will be shaped by the way in which their disciplinary practices work through and on them. (p. 197)

Willmott (1994), combing the work of Foucault (1977) with a psychoanalytic frame, also argued

subjection is accomplished through the development of modern organizational practices and institutions—such as the clocking in system, the open plan office, or the appraisal system—that promote an accountability of self …. Through their operation, modern subjects are constituted whose sense of self-identity is invested in the reproduction of these practices—not simply to achieve material rewards or avoid punishments but to gain and confirm a sense of their own normality as sovereign subjects. (p. 106)

Willmott (1994) and Schwartz (1987) similarly argued that individuals willing tie themselves to organisational ideals and standards of performance that promise self-knowledge to confirm and alleviate the burden of responsibility and anxiety associated with the modern constitution of the individualised, responsible, sovereign subject.

Miller (1986) and Rose (1999), drawing on the work of Foucault, researched and examined the history of psychology showing how particular constructions of subjectivity are embedded within or constituted through discursive formations and practices. According to Rose, management now requires attending to the subjectivity of employees. Our personalities, subjectivities, and relationships are not private but are intensely socially organised, governed, and managed.
A new expertise (psychology) has arisen with a
new language for construing understanding and evaluating ourselves and others
.... Our thought worlds have been reconstructed, our ways of thinking about
and talking about our personal feelings, our secret hopes, our ambitions and
disappointments. Our techniques for managing our emotions have been
reshaped. Our very sense of ourselves has been revolutionised.

(Rose, 1999, p. 3)

Knights and Morgan (1994) similarly argued that the organisation is crucially a sphere for
the construction of subjectivities. They asserted “the study of organizations is no longer
about the way commodities are produced; it is about how subjectivity is produced.
Organizations do not so much produce things as people” (p. 137). In one of the few
organisational studies that acknowledged gender construction, they argue that not only is
subjectivity constructed within the organisation but that organisations construct the
subjectivity of consumers. Knights and Morgan identified informal knowledges about
normality and deviance as well as systematised bodies of knowledges. They emphasised that
the increasing service sector is important with subjectivities of consumers and employees
becoming interdependent and with the work of employees being directly under the gaze of
the customer. They further argued that the constitution of particular forms of subjectivity
generates from knowledge and practice in many fields of power, none of which are totalising
so the subjective identity of individuals is more complex than simple categories. Deetz
(1994) also researched identity formation in the workplace, concluding the attempt by
workers to produce a unitary self, and the self-surveillance required to produce that self,
produced closure on any self-differentiation or pursuit of alternate understandings of self
with coworkers. Similarly, Mills (1993) has argued that notions of the self have had primacy
and have helped to create various senses of the self largely in the image of the organisational
practices from which they arise. Organisations “have been crucial sites for the construction
of gender and self” (p. 144).

Several studies have identified the shifting and multiple subjectivities of workers including
the identity talk or positioning practices within appraisal and grievance hearings in the
finance sector (Austrin, 1994), the gendered forms of work practices of temporary women
clerical workers (Gottfried, 1994), and of the constructed, gendered, ambiguous, and
fragmented multiple selves of Japanese factory workers (Kondo, 1990). That managers and
technocrats participate in organisational sabotage as a result of interests, values, and motives
that do not align their subjectivity with the organisation has been described by LaNuez and
Jermier (1994). Individual subjectivity is not sovereign and persons exist in a state of
continuous construction and reconstruction where each reality of self gives away to another
reality of self (Clegg, 1994; Gergen, 2001). Collinson (1994) described how the disciplinary
shaping and conformity of individual identity and subjectivity may be resisted in many ways including by distancing (either symbolically or physically), and by persistence which appears the most effective being greater involvement in the organisation and negotiation in determining meaning.

Further postmodern research has identified subjectivity and identity to be central to social organisation and therefore organisations. O'Doherty and Willmott (2000) problematised identity and reformulated the subject within labour process theory highlighting the fragility of order in social relations at work and identifying novel spaces of resistance. Townley (1993) utilised a Foucauldian power-knowledge perspective to analyse human resource management asserting that it could be understood as a discourse and set of practices about the indeterminacy of the employment contract. She further suggested that human resource management employs disciplinary practices to create knowledge and power including spatial distribution, the use of developmental appraisals as confessionalists, and mentoring to constitute and identify correct formation of subjectivity. Discourse analysis was utilised by Hardy (2001) to research organisations, focusing on language and conceptualising societies, institutions, and identities as discursively constructed collections of texts. Following this theme Grant, Keenoy, and Oswick (2001) argued that discourse analysis identifies ways in which discursive practices are deeply implicated in a wide range of processes of organising, highlighting the role of discourse to socially construct reality for organisation members thereby shaping and influencing organisational members attitudes and behaviour.

Casey (1995) undertook an ethnographic study informed by critical, postmodern, and psychoanalytic theory within a large US multinational company. She aimed to identify social structures and discursive practices that shaped modern workers notion of self. Casey identified a founding myth or narrative regarding the founder of the company as a scientific inventive genius, a courageous leader and an exemplary corporate citizen. This narrative was evoked and retold in training seminars, in written materials, and informally to continue summoning cultural organisational images of heroic strength, resilience, and innovation tempered by paternalistic care and responsibility.

Casey (1995) further identified a new culture (commensurate with some organisational literature) which aimed for employees to believe that their self-development, their source of self-fulfilment and identity, would be found in working for the corporation. The notions of team and family were introduced to flatten hierarchies, to encourage participative decision making, to foster provision for employees to feel valued, and to promote their sense of identification with the company. Casey argued that as notions of teams and family developed, they became forms within which people identified their place within the organisation, increasingly displacing the former locus of occupational identification. Teams,
however, simultaneously provided for employees to police themselves and what could be asked and suggested was implicitly censored and lead to self-censorship for promotion. An elaborate corporate vocabulary existed including customer focus where employees also became customers, thereby disintegrating the former differentiation between workers and customers. She argued perceptions of participation and empowerment disguised their actual absence.

Casey (1995) further found employees were encouraged to volunteer to participate in community after-hours programmes, reinforcing the discourse of exemplary corporate citizenship. Official discourse of the employee promoted values of diligence, dedication, loyalty, commitment, to be adaptable and flexible, and the ability to be a team player. Persons who deviated too far from this socially constructed norm would be disciplined or would self-select out. By complying with the requirements of appropriate attitudes and behaviours, employees internalised particular characteristics, values, and practices that constituted their selves and that also transferred into social interactions outside of the workplace. Teams and families were discourses designed to win employees hearts and minds by identification with the organisation and simultaneous disintegration of identification with occupations, guilds, and unions. Casey described this as the crafting of designer employees or the corporate colonisation of the self. This crafting and negotiation of subjectivity has also been described by O’Doherty and Willmott (2000) and Sewell (1998) who combined Foucauldian and labour process insights to further the notion of team-led self-surveillance. In examining the combination of teams with current technological information systems, they argued that unobtrusive control of workers was exercised. This was similarly identified in an Australian study of Scheeres (2003) that found an increased requirement of worker participation and workers to verbalise and textualise their roles in public forums such as meetings which elicited bottom-up offers of worker involvement. Employees became aligned with organisational values and goals, became discourse workers, and assumed the new work identity.

Within nursing, there has been an increasing number of inquiries informed by postmodern and post structural perspectives that have investigated and analysed discourses that shape and constitute nursing roles, identity, and subjectivity. Mohr (1999), in deconstructing the language of psychiatric nurses’ documentation and charting, exposed the vulnerability of psychiatric nurses to ill-construed biases, hasty judgements, and professional assumptions about patients. Liashchenko (1997) identified spatial vulnerabilities such as poverty, patient exploitation, homogenisation of identity, and gendered space when investigating ethical concerns of nurses. The research of Cheek and Gibson (1996) identified that scientific/medical and legal discursive frames shaped the role of the nurse in the
administration of medication with rituals serving to act as mechanisms by which nurses police each other, reinforcing the notion of control and docility. Similarly, Walker, K. (1994) identified that the discourses of science and caring could be exposed in particular representational technologies and practices such as art that displayed nursing’s collusion with the *truths* of science, at the expense of caring (Walker, K., 1994). Nelson (2001a), in a discursive analysis, argued that civic and patriotic discourses provided the framing for the secular nurse’s subjectivity and by which nurses negotiated care of the sick and male bodies without protection of vow or veil. Dickson (1990) interviewed women and identified alternate knowledges of menopause to that of the male medical science discourse evident in the nursing literature. Davis (1998) deconstructed and reconstructed the texts (fieldwork notes and interviews) from her ethnography of rural community nursing practice and primary nursing, identifying discourses of gentleness, closeness, therapeutic friendship, mutuality, and the gift of desire—empowering and compassionate relationships. Similar to the previously discussed Singaporean study of managerialism that identified subjectivity construction (Hau, 2004); Latimer (1998) also examined nurse subjectivity. Latimer, in an ethnographic study of older people in an acute medical unit, concluded that nurses’ assessment of patients could be considered a process of organisational alignment that accomplished complicit managerial and medical objectives and that also shaped both patients’ and their own identities. Nurses aligned themselves with being professional, which was to perform themselves into pre-scripted professional roles of competent, good, and caring. This involved the “continuous purification of the medical domain by participating in the staging of decisions” such as the spectacle of certainty and decisions at medical rounds (p. 53).

**Summary**

Notions of leadership, management, and administration display shifting conceptions and ambiguity within organisational and nursing management literature. A fixed meaning to these terms can be contested, however, a close examination displays that a power relationship of influence in respect to the leader or manager, and those led or managed, is usually implied. Preference for the term leadership is seen to exist in the literature connected with notions of progress whilst the term management if often denigrated and aligned with notions of control. Most nursing texts have uncritically accepted the use of the terms, however most studies still depict a leader as being a nurse who holds a management position. Nursing literature has uncritically accepted and adopted many management and/or leadership concepts that have been contested in the literature, and has conducted sparse research in this area. Nursing texts are predominantly prescriptive of what a good nurse should do in order to
attain management status. The normative roles and functions given in these texts are predominantly antithetical to the intuitive political and communicative work of managers established in the research. Literature that has been documented of nurses’ experiences focuses principally on senior leaders, who are celebrated for their extraordinary achievements.

Discourses that inform the literature include normative, positivistic, technical, functional, and rational accounts, as well as marginalised and critical voices, the discourse of managerialism, empowering and shared relations, instrumental patriarchal accounts and, more recently, the discourses of identity and subjectivity management. The dominance of instrumental and patriarchal discourses is evident and is particularly apparent in nursing literature. Some feminist studies have investigated organisations, however, further research has been demonstrated to be required. Critical or postmodern studies of discourses, identity, or subjectivity specifically related to managing nurses or being managed by nurses in critical care, could not be identified in the literature. Some nursing studies, however, utilising critical, feminist, and postmodern methodologies, have elicited differing conceptions and discourses of caring rather than only the instrumental patriarchal discourses. Most nursing studies of subjectivity have sought to identify a singular self, whilst other postmodern and feminist organisational studies have identified multiple constructions of subjectivity and explored the concept of subjectivity management. In the following chapter, chapter four, the literature review focuses specifically on nursing and briefly outlines and critiques discourses within the literature of the social relations within nursing.
Chapter Four

The social relations and
organising of nursing—
*Reviewing the social scripts*
Introducing the social relations of nursing—*The social scripts*

This chapter is the second of three chapters that reviews the literature pertinent to nursing management. Whilst a large proportion of the literature in respect to nursing management relates to issues such as budgeting, scheduling and time management, this chapter specifically focuses upon the social relations and organising of nursing. This is inclusive of nurses and nurse managers’ interpersonal relations. Within the literature three major themes or aspects were identified which are utilised to structure this chapter. These themes pertain to the image and value of nursing work, the professionalisation and status of nursing, and finally, the structural and cultural organising of nursing. Together these identify and reveal the values and issues inherent in the social organising and social relations within nursing.

The image, identity, and value of nursing work—*Daily skipping, lightly tripping, smiling brightly, so politely … maidens …*

The literature supports that the work and image of nurses including critical care nurses is, in general, valued poorly (Kalisch & Kalisch, 1987; Malko, 1991; Strasen, 1992; Tellem, 1984; Wood, 2000). This ongoing issue has again been confirmed in the Australian *National Review into Nurse Education* (DEST & DoHA, 2002) and the *Report on the Inquiry into Nursing* (SCAC, 2002). Nurses are aware of the public perception of their image, particularly in respect to being dependents of doctors (Takase, Kershaw & Burt, 2001). The negative media portrayal of nursing with stereotypes of angel of mercy, girl Friday, heroine, mother, and sex object perpetuates the images (Dunn, 1985; Kalisch & Kalisch, 1987). Aber and Hawkins’ (1992) study found that portrayals of nurses were stereotypical and demeaning of nurses even in advertisements in medical and nursing journals. Chiarella (2002) identified five different images of nurses: the ministering angel, the domestic worker, the doctor’s handmaiden, the subordinate professional, and the autonomous professional, which exist within the law as it insufficiently recognises nurses’ presence and work in health care. Wood (2000) depicted the image of nursing to be one of manual labour mostly performed by women and, like motherhood, is considered an essential, but unpaid, contribution to the work of society with rewards that are intrinsic to the job.

Conversely, managers are usually aligned with a superior and elite status (Rost, 1994), and higher intelligence is described as a common trait among leaders (Bernhard & Walsh, 1995; Marriner & Tomey, 2004). Nurses are held to be highly regarded and respected for their ethical standards and honesty (Gallup Organization Poll, 2003), however, their cross cultural image is that of being weak and not well educated, knowledgeable, or scholarly (Austin, Champion & Tzeng, 1985; Campbell-Heider, Hart & Bergren, 1994; Donley & Flaherty, 1990). As society has consistently and systematically undervalued care, so the work that
nurses perform as carers has been marginally valued (Brykczynska, 1997; Evans, 1997; Malko, 1991). Roberts (1983) identified important values to nurses of warmth, nurturance, and sensitivity have been viewed less favourably when compared to the dominant culture of medicine, that is, intelligence, decisiveness, and lack of emotion. Historically, the sexual division of labour based upon biological characteristics has been viewed as natural and assumptions of a woman’s nature destined her role in society. Davies (1995) linked femininity with caring, contending that

its stress on dealing with dependency, acknowledging emotions and intimacy and nurturing others … represent qualities that are feared and denied in masculinity, qualities that at best are seen as to be contained and allocated to a different sphere, and at worst are repressed or treated with contempt. (p 183)

Reverby’s (1987) historical account of American nursing linked the work and identity of nurses to womanhood. The link of womanhood to nursing extended to the duty of any females within a family, however, female virtue and responsibility could be lifted by supervising another woman to perform such functions.

Nursing is grounded in the expectation that caring was part of a woman’s duty to her family or community. As some nursing moved out of the realm of unpaid family labour into the marketplace, the assumption that it would still be the work of love, not money remained …. [With training] genteel ‘good’ women were to become disciplined soldiers in the war against disease and disorder, self-sacrificing mothers to the patients, efficient house-keepers for the hospitals, loyal and subordinate assistants to the physicians and firm supervisors of the hospital’s other workers.

(Reverby, 1987, pp. 2-3)

McPherson (1996), in her study of Canadian nurses, contended class, race and gender were important factors in the development of Canadian nursing. Gender asymmetry with the hierarchical division of labour complicated any class consciousness between managers and workers for nurses. Game and Pringle (1993) similarly noted “the division of labour in health represents a sexual division in its most blatant from ….In no other work places are power relations as highly sexualised as they are in hospitals. Bureaucratic domination is directly reinforced by sexual power structures” (p. 94). In tracing the development of Australian nursing, Burchill (1992) identified a continuing historical class difference between nurses and nurse administrators. This was further supported by Godden (1995) who described the status of matrons and lady superintendents to be far superior to that of the nurses, with many of Australia’s first matrons being the daughters of prominent men. Bashford (1997), in her study of early Australian nurses, noted the confusion, contradictions, and insecurity in nurses’ discourses as they grappled with multiple images of work in religious, scientific, and professional terms.
Reverby’s (1987) and Nelson’s (2001b) studies highlighted nurse training as the development of a certain character that was enforced and whereby the ideal nurse was forged from the natural qualities of the good woman. Submission and self-sacrifice, rather than independence and individualism, were stressed; altruism rather than individualism defined the appropriate moral state. Drill and constant harsh discipline were the hallmarks of training to result in implicit unquestioning and prompt obedience, punctuality, neatness, quietness, pleasing manners, cleanliness, as well as internalised self-discipline in calmness, and self-control. Reverby asserted “order was indeed created, but by repressing the humanity and innovation and caring skills of students” (p. 65). More current studies of the socialisation of student nurses in universities and in clinical practice indicate that many of these socialised norms continue (Allen, 1990, 1996; Clare, 1993; Mozingo, Thomas & Brooks, 1995; Walker, K., 1994). The subordination to the practice of medicine and socialised suppression as well as the perpetuated myths regarding nursing eventually undermines nurses’ self-image and confidence in themselves (Kalisch & Kalisch, 1987; Malko, 1991). Conversely, Allen, D.W., (1998) in a study of senior nurse leaders, identified self-confidence and the reinforcement of self-confidence by significant others and life/work experiences to be crucial in the development of nurse leaders.

Defining the work of nurses has been problematic and has received considerable scholarly attention (Cohen 1981; Henderson, 1964; Mauksch, 1966;McCloskey & Grace 1990). Brewer (1983), in an ethnographic study of nursing practice, described nurses’ difficulty in defining nursing and concluded that nurses were “tacitly aware of so many other objectives which were not related to patient care” (p. 32). Mauksch (1966) in a seminal work analogised nursing to the pattern that remains after the cookies have been cut from a sheet of rolled-out dough. Some functions removed from nursing have developed into independent specialties, yet nurses are expected to assume responsibility for these functions on weekends and night duty. The hospital or service coordinating role and work of nurses is noted in numerous studies rather than the work of direct patient care (Ackroyd, 1995; Brewer, 1983; Mauksch, 1966). Liaschenko (1997) described boundary work as the hidden connecting and relational work of keeping the patient cared for and the institution going. Mauksch described this role as the hidden coordinator of institutional function that lies heavily on every nurse and devalues specific nursing expertise.

The institutional coordinator function arises from nursing being bound to represent continuity in time and place within the hospital, from enacting the extended arm of hospital administration, from coordinating the directives for care from numerous medical staff, and from coordinating other care professionals and institutional requirements for patient care (Mauksch, 1966). Mauksch argued that the coordinating role was an informal role and whilst
appreciated is poorly recognised or rewarded and, like Wolf (1990), recommended an overt and clearer identification with clinical practice for the true value of nursing to be recognised. Leaders, as clinical experts able to demonstrate best practice to others, are an important component of clinical leadership (Booth, 1992; Cameron-Bucheli & Ogier, 1994). Similarly, Sweeney and Witt (1990) and Kuhn (1985) advocated that nursing’s power base originated at the bedside and that practice should define nursing’s field of responsibility.

Fedoruk and Picombe (2000) and Wolf (1990) raised concern with the extended role of the nurse executive in managing extended portfolios of managerial responsibility that come with titles that include notions such as client services. They maintained that whilst the status of the individual may be enhanced, nurse managers have been seduced into enacting the suggestion that more skill is required to manage client services, which further divides nurses and consolidates the nurse executive with the male management ethos. Ackroyd (1995) differed in his opinion of what work role nurses should perform, advocating that they should maintain their hospital coordinating role they have historically performed so well rather than be replaced by general managers.

Case management is a role that has emanated from the US with its links to clinical pathways and managed care. It has recently been advocated as a role for nurses whereby they coordinate, sequence, and monitor the care requirements and needs of clients (Zink, 2001). Zander (1990) argued that nurses should assume this role because nursing is the glue that pulls and holds a hospital together. It has been further argued that nurses should assume this role because as system coordinators and integrators of the total hospital experience it is logical and cost effective (Joel, 1990). Furthermore they should assume this role because they have all had formal training in every segment of health care, they are generalists, detail people, they excel in managing care, are committed to the institution, and are willing to assume more authority (Zander, 1990). In a critical and feminist analysis of case management, Padgett (1998) argued that case management creates a conflict for nurses between meeting client needs and corporate goals, views health care as an industrial product, and places the burden of reconciling profit with care on the nurse.

Nurses have often indicated their work is not valued by administrators who feel their work is interchangeable, ignoring differences in age, experience, education, or specialty preparation in reassigning responsibilities (National Commission on Nursing Implementation Project, 1987) and that they are viewed with a pervasive sense of charity, sympathy, and lack of equality (Mauksch, 1990). The literature supports that nursing work has historically been poorly valued and aligned to the intrinsic nature of women. Nurses have internalised this lack of value, resulting in a loss of confidence and self-esteem. The work performed by nurses often is linked with coordinating responsibilities, which may be argued to be essential
to the work of nurses or an attempt to gain status through extension of the nursing role and shift from clinical nursing responsibilities. Management positions within nursing similar to the prestige generally accorded to positions of management have held a much higher social status. The status of nursing is further explored in the following section in respect to professionalisation and its impact upon the social relations of nurses.

The bureaucratic and professional dilemma: Striving for professionalisation and status—Cuts both ways

Nursing management literature is replete with studies that promote nursing management and nursing leadership as a vehicle for increasing individual and collective occupational status and as a mechanism to gain parity with other health care professionals. Leadership is frequently portrayed as the hallmark or key to the professionalisation of nursing (Bernhard & Walsh, 1995; Salmon & Vanderbush, 1990). Successful nurse managers are portrayed as accomplishing a multitude of feats, including being effective (Sullivan & Decker, 2001; Yoder-Wise, 2003), having satisfied staff (Cullen, 1999; McNeese-Smith, 1997; Morrison, Jones & Fuller, 1997), coaching and mentoring staff (Dunham-Taylor, 2000; Vance, 1999), inspiring and motivating staff through projecting a vision (Bennis, 1999; Mahoney, 2001; Manfredi, 1996), communicating well (Marriner Tomy, 2004), and empowering their staff (Fullam, Lando, Johansen, Reyes & Szaloczy, 1998; Morrison et al., 1997; Swansburg & Swanburg, 2002). Some literature has advocated for the early identification of potential nurse leaders with selective skills (Cadman & Brewer, 2001), and for further education for nurse managers (Duffield & Franks, 2001; Henry, Hamran & Lorensen, 1995; Ulusoy, Smith & Knill-Jones, 1996). The implication can be drawn that past problems for nurses may be at least partly attributed to a lack of qualities, skills, or knowledge on the part of nurses.

It is argued that nursing as a profession requires representation within the top levels of policy and decision making in order to ensure the voice of nursing is not silenced (Mahoney, 2001; Smith, 1990) and to improve the future of nursing (Donaho, 1990; Yoder-Wise, 2003). According to Porter-O’Grady (1990), the nurse manager can demonstrate the value of nursing to the organisation. Grant and Massey (1999) identified functions of a nurse leader which included the utilisation of nursing codes of ethics and standards of practice as guidelines for individual and professional accountability. However, the dilemmas of professional versus bureaucratic values for nurses and nursing leaders are well documented (Cohen 1981; Froebe & Bain 1976; Johnson, 1971; Traynor, 1994; White, 1986; Wigens, 1997), as well as the male ideological basis of professionalisation itself (Bates & Linder-Pelz, 1990; Beletz, 1990; Turkoski, 1995). This literature argued that nursing values conflict with bureaucratic values in large organisations. Further organisational literature, however, contests this position, arguing that many of the traditionally recognised professions exist in
large bureaucratic organisations, however, their social organisation differs to how nursing and non-professions are organised (Ringerman, 1990). Ringerman’s research concluded “the traditionally held belief that organizational values and professional values are often in conflict may be subject to question” (p. 343). This is further explored later in this chapter in the section on professional and non-professional structure.

**Professionalism or proletarianism—*Get a job***

Melosh (1982), in an analysis of the divergent and multiple approaches to collective actions of American nurses, identified a work culture of rank and file nurses that differed from the professional ethos supported by the nursing elite. Melia (1987) also utilised the term nursing elite and described claims of professionalism within nursing as an attempt by the elite to make subordination more palatable. Melosh challenged nursing leaders to develop a strategy of change other than professionalisation that was less exclusive and that was aligned with other working class caregivers rather than the medical profession. Similarly, the study of American nursing by Reverby (1987) clearly described how the desire to care was not valued and identified how the strategy of professionalisation had been of little benefit to the average nurse. Reverby noted “[nurses were] so divided by class that their common oppression based on gender could not unite them” (p. 6). Mark’s (1994) study of race, class, and gender in South African nursing again identified professionalisation as a strategy that divided nurses more than it united them. In a study of student nurses’ experiences in the UK, Schurr and Turner (1982) explored the use of the term *professional concluding*

> Managers … use the term ‘profession’ in the sense of professional conduct. In this usage the term has overtones of professional etiquette rather than with occupational status and ideas of independent practice. Once students have been socialized into the ways in which a nurse is expected to behave, managers make appeals to ‘professional’ behaviour; these become the mainstay of discipline within the nursing service. (p. 169)

Carpenter (1977) and Schurr and Turner (1982) concurred that nursing service managers utilising a business administration philosophy preferred a conformist and efficient workforce rather than independent-practitioner nurses looking for autonomy and freedom of practice. The high-skill professional with extensive education, significant operating autonomy, and perceived status presents a challenge to management as the qualities that make that individual professional, independence of thought and action, self-motivation, self-confidence and a sense of responsibility are also characteristics that can make people tough to manage (McConnell, 1994).

The interplay of professionalisation and proletarianism in American nursing has been examined by Coburn (1988) and Brannon (1994) who concluded that rather than
professionalisation there has been an increased prevalence in the incidence of wage work, organisational control of nursing work, fragmentation, accountability, and deskilling. Lawler’s (1999) critique of the representation of nursing work and Herdman’s (1998) ethnography of the nature of nursing work of Australian nurses similarly concluded nursing has been subject to increased regulation, more stringent controls, and that there has been widespread deskilling of the majority of registered nurses. Herdman asserted professionalisation within a context of rationalisation has led to knowledge without power and that the bedside discourse of nurses is frequently unheard as it is dominated by official reports and accounts. She concluded nurses believed nurse administrators undervalued them. Coburn (1988) and Wagner (1980), similar to Reverby’s (1987) historical analysis, depict nursing as having lost control of the nursing labour process. Leaders have hidden the similarities of nursing with other underpaid female workers—in order to retain control over their ranks (Wagner, 1980). Reverby stated “the average nursing superintendent … found herself constantly pressured to serve the institution’s and physicians’ demands before the needs of the students. Ultimate control of nursing was out of her hands” (p. 75). Conflict with hospital administration, the dominant occupation of medicine, and the state ensues when nurses attempt to gain control over their labour process.

Davies’ (1976) analysis of nurses’ control over their work concluded that nurses’ lack of control emanated from a historical context that has created dependence on superiors in the nursing hierarchy. The occupational strategy of routinisation served to protect nurses from the demands and stress of patients, from doctors’ whims, and also enabled work to continue occurring with a high staff turnover which has consistently occurred in nursing. Campbell (1992) in an analysis of nurses’ professionalism in Canada, also argued that nurses’ desire for professional and career mobility led them to align themselves with contemporary governing and objective modes of organisational consciousness and practices so that professional judgements once made by individual nurses are now rendered into organisational judgements made through complex documentary processes as part of the systematic ruling apparatus. Despite the professional discourse that claims efforts to gain increased recognition, the literature casts doubts on notions of major progress for the individual nurse. The structural and cultural organisation of nursing discussed in the ensuing section follows the theme of professionalisation as it examines the literature pertaining to the social organising of nursing and compares this with social organising within traditional professions.
The structural and cultural organising of nursing—The military polonaise

Hugman (1991) identified the occupation of nursing in order to gain some power organised itself hierarchically under domination of both the state and medicine, unlike the occupations of law and medicine which, reflecting larger social values of gender and class, were able to self-regulate and occupationally develop more collegiate relations. Wilson (1992) described nursing management as having been based upon the Western positivistic paradigm with a predominance of machine-like orientation to work and an autocratic and bureaucratic structure. The structural managerial hierarchy allows the expertise of management to take precedence over the technical competence, knowledge, and craft of the occupation (Bellaby & Oribabor, 1980; Hugman, 1991). Holton (1984), in a feminist analysis of the writing of Florence Nightingale, described surveillance and regimentation as essential techniques in Nightingale’s nursing programme with a policing force of womanhood. Reverby (1987) similarly described the work of nurses in hospitals as industrial slaves and hospital machines. She noted that Nightingale’s format for nursing reform whilst seeking to free women from the bonds of familial demands indeed rebound them by its female hierarchy.

The historical links with military style hierarchy and regulation are well described (Dolan, Fitzpatrick & Herrman, 1983; Reverby, 1987). More recent studies of nursing organisation again depict regimentation and hierarchy as essential elements of nursing organisation. Mackay (1989), in a study of nurses in the UK, cited a student nurse describing her opinion of the ward sister: “she was a slave driver but the ward was excellent. I didn’t like her as a person but she ran an extraordinary ward” (p 109). This depicts the social relations seen in the non-professional hierarchy as Mintzberg (1979) stated “in the non-professional hierarchy, power and status reside in administrative office; one salutes the stripes, not the man” [sic] (p. 361).

Owens and Glennerster (1990), researching nurses in management following organisational changes in the NHS, identified that despite structural changes to a diminished hierarchy, decentralisation, and devolution of authority the old hierarchical structure still shadowed the new management positions. Strong and Robinson (1990), in an ethnographic study also of the NHS, described nursing as being dominated by an outlandish sense of hierarchy with a quasi-military discipline extending throughout every level of the nursing organisation. Attempts at professional development met with considerable opposition from senior figures within nursing’s own ranks as many nurse mangers positively enjoyed bossing their subordinates. Enhancing junior staff skills was too threatening to senior staff status (Strong & Robinson, 1990).
More recently, Gavin, Ash, Wakefield, and Wroe (1999) have argued that despite the introduction of shared governance into hospitals within the NHS, the culture at ward level has not changed. They asserted senior nurse managers who poorly understood the concept of shared governance also actively sabotaged it. Edmonstone (2000) provided some support for this in contending that empowerment of staff and shared governance is unlikely to be successful in a mechanistic and regulatory system where the hierarchy is still maintained and where there is no shared commitment. Boyce (1993) in examining hospital structures, and Manthey (1989) in examining control over nursing practice, argued that decentralisation of management structures do not of themselves ensure decentralisation of power or authority and frequently it is only responsibility that is devolved.

Keen and Malby (1992), in an analysis of six hospitals within the UK having introduced devolved management structures, noted that despite the role of the director of nursing being retained in some hospitals, it did not ensure an effective voice for nursing as much depended upon the personality of the nurse, and the willingness of managers and directors to take nursing views into account. Furthermore, nurses would be called upon to agree to decisions about changes of skill mix or extension of the nurses’ role; however they were unable to prevent the implementation if it was deemed financially necessary. The literature attests the historical and current social organisation of nursing has been that of a marginalised occupation and has not overtly resulted in reform, progress, or an increased voice for nurses.

**Professional and non-professional structure—The very model of a modern major general**

Contrary to the professional bureaucratic conflict arguments utilised to explain problems and conflict in nursing, Mintzberg (1979) and Etzioni (1969) have argued that professionals can exist relatively harmoniously in a bureaucracy or large organisation. They noted, however, the structural and cultural differences in the social organisation of *professions* compared to *non-professions*. They argued medicine and law, which have shaped the very criteria by which traditional professions have been judged have existed in large organisations and bureaucracies, however, their social organisation differs remarkably from nursing which organises itself in a semi-professional or non-professional manner. More recent studies have concurred with this notion that professional values can satisfactorily exist within a bureaucracy (Hewison, 1993; Manthey, 1989; McCloskey & McCain, 1987; R ingerman, 1990) where expert power and positional power are aligned. However, some debate within nursing remains (Traynor, 1994; Wigens, 1997) and it has been argued that the social change would require considerable strategic and sustained effort (Rosenow, 1983). Mintzberg (1979) described what he termed a *professional bureaucracy* where indoctrinated specialists had considerable control over their work. Coordination occurred largely from the professional standardisation of skills, training, and indoctrination of these professionals.
Rather than authority of a hierarchical nature (the power of office) “in the professional hierarchy, power resides in expertise; one has influence by virtue of one’s knowledge and skills” (Mintzberg, 1979, p. 360). Standards for its operation originate largely outside the organisational structure in professional associations and colleges where self-governing professionals join with their colleagues from other professional bureaucracies. Mintzberg stated “what frequently emerges in the professional bureaucracy are parallel administrative hierarchies, one democratic and bottom-up for the professionals, and a second machine bureaucratic and top-down for the support staff” (p. 360).

Within large bureaucratic hospitals the duality of hierarchies is clearly visible. The medical profession occupies the more democratic bottom-up hierarchy where authority is based on expert medical knowledge such as the consultants and specialist surgeons, whilst nursing occupies the machine-like, top-down hierarchy where authority is based on administrative rank or position rather than nursing expertise. Mintzberg argued that “unlike the professional structure … one must practice administration, not a specialized function of the organization, to attain status” (p. 361). Professionals often judge management to be less than a profession in its own right and inferior to the profession that is managed (McConnell, 1994).

The medical bottom-up structural hierarchy appears to be challenged with administrative control increasing in power due to the recent emphasis on business skills and economic efficiency. However, the nursing top-down hierarchy of authority depicted in Figure 1 has been well published (Brewer, 1983; Fedoruk & Picombe, 2000, p. 16; La Monica, 1983, p. 9; Sullivan & Decker, 2001) and is strengthened with the accentuation of economic and administrative values. In the nursing hierarchy the most senior person, (director of nursing or nursing executive), is usually structurally positioned alone as a single person where the skills of management are held to be of most value. In the professional hierarchy, several experts, (professors in universities, specialist consultants, or surgeons in medicine) who practice their specialised expert function within the organisation, occupy the most senior or powerful positions. The skills and knowledge of these professional practitioners have been held as equal in value to, or of greater importance than, the management skills of administration.

Kennedy (1990) claimed with the introduction of clinical directorates that “consultants will not accept being directed …. Heaven help the unit general manager who tries to delegate responsibility for carrying out annual reviews of job descriptions with consultants … the manager has more of a supportive or facilitative role” (p. 214). This reflection of values can be also seen with the recent development of clinical directorates where “clinical directors were typically senior medical staff managing on a part-time basis, supported by a full-time nurse manager” (Clinton & Nelson, 1995 p. 602). The medical specialist maintains their professional practitioner skills and expertise whilst nursing contributes a full-time nursing
administrator or manager quite removed from clinical practice. An inversion of this structural triangle has been briefly outlined by Leftridge and Young (1998) in respect to recommending that turning the triangle upside down would be beneficial for interpersonal relations within nursing.

Figure 1  Hierarchy of authority

![Hierarchy of authority diagram]

( adapted from Brewer, 1983, p. 33)

The structural organisation of nursing with only one authoritative senior position which is administrative, questions the vulnerability and ease of replacement of this position at the top executive level, and could also partially explain the lack of voice for nursing and turnover rate at the most senior nursing level. Kippenbrock’s (1995) survey of chief nursing officers in the US found the most frequent duration of employment for these senior nurses was 1 and 3 years. Similarly other studies have reported the tenure of chief nursing officers to be 2.5 years or less (Henderson, M., 1995; Lee & Henderson, 1996) and in a 10-year study the average tenure for a director of nursing was 3.4 years (Freund, 1985, 1987). This is reflective of Strasen (1992) who stated “if you want to proceed on a nursing leadership path, you must prepare yourself to be fired at any time” (p. 128). Adams, Miller, and Beck (1996) also reported 78% of nurse executives and 70% of middle managers in their study to have held their position for 1 year or less. Ulosoy et al. (1996), in a Scottish study, reported 78% of managers to have been tenured for 4 years or less. More recently, Dunham-Taylor (2000) reported, in a study of 396 executives, that 66% were holding tenure for 5 or less years and 29% had a tenure of 1 to 2 years. Unless nursing leaders can demonstrate the ability to provide more cost effective care, they may not be included at an executive level in any new management arrangements and they are frequently terminated when a new chief executive officer commences (Clinton & Nelson 1995; Singleton & Nail, 1988). Bradshaw (2002) documented pressures placed upon managers from the hierarchy within hospitals and government bodies in the UK to meet unrealistic and unfair performance indicators. Bradshaw further contended that these indicators must be met to avoid threats of dismissal.

The literature indicates that the most senior nursing position within an organisation is placed in a tenuous predicament to maintain their professional alliance with nursing. The absence or
lack of literature documenting nurse managers’ experience of managing nurses, with the exception of heroic and historical accounts, is also notable. Fedoruk and Pincombe (2000) argued that nurse managers are marginalised by the nursing workforce who does not see their relevance, from a male management culture because of gender, and also from a perception that their educational preparation is inadequate for a senior role. Irurita (1990) and Roberts (1997) described a perception of nurse managers as having reached their positions due to allegiance with the status quo. White (1986) argued nurse managers had internalised the values and belief systems of the new peer group so, whilst ostensibly representing nursing, they voted against nursing and its concerns to maintain their status and positions. The non-professional organisational structure of nursing enables non-nursing groups to control the activities of all nurses. Furthermore, the relationship between specialist nursing groups who often assert that they hold high specialist clinical values and senior nurse managers can be speculated.

**Social culture—Stayin’ alive**

As well as the structural organising of relations within nursing, the social culture also reflects how nurses organise or relate to each other. McDaniel and Stumpf (1993) advocated for a change in nursing culture and described this as “the ways of thinking, behaving and believing that members of a unit have in common” (p. 54). As well as the bottom-up structure, collegial and supportive relationships exist in professional cultures that emanate from a sense of shared values and respect for professional expertise (Greenwood, 1984; Mintzberg, 1979). The literature has documented a lack of this professional social culture within nursing. Collegiality seen in other professions was reported as less apparent among nurses in the US Nursing Knowledge Project (Gorman & Clark, 1986). Mackay (1989) described the social relations of nurses with nurses by detailing an aspect of overt bitchiness, lack of support from colleagues, failure to communicate, misogynistic, and subservient attitudes inculcated during training, resulting in mutterings and discontents becoming the norm.

More recently, Farrell (1999) and Farrell and Bobrowski (2003), in Australian studies of 270 and 2400 nurses, depicted horizontal violence, aggression, and interpersonal conflict within nursing. Furthermore, 30% and 64% respectively of nurse participants in these studies experienced this as a daily event. Farrell (1999) identified non-nurse managers as the least responsible for workplace aggression toward nurses compared to nurse managers who were found to consistently use aggression toward nurses. Hegney, Plank, and Parker (2003) surveyed 1436 Queensland nurses finding high levels of reported workplace violence from nurses. Less experienced nurses were more likely to report workplace violence than more experienced nurses. Whilst not specifically discussed, this study included a table of data
indicating that nurses reported between 36% and 52% of all workplace violence to be from the combined source of other nurses and nurse management. Jackson, Clare, and Mannix (2002) also depicted the workplace of Australian nurses to be violent, hostile, and aggressive and described the culture to be inclusive of aggression, harassment, bullying, intimidation, and assault emanating from patients, relatives, other nurses, and other professional groups. They suggested managers often accept this culture and are also often implicated in this violence. Similar results were found in a study of 141 nurses in a variety of acute care units (Cox, 2001), in a study of nursing students (Randle, 2003), and in women nurse academics in Australian and US university schools of nursing (Glass, 1997, 2003a, 2003b). All of these studies called for managers to stop fostering and supporting a work environment where bullying and violence are a taken-for-granted phenomenon and to improve the work culture and environment of nurses.

Several phenomenological studies from interviews with male (Brooks, Thomas & Dropleman, 1996) and female nurses (Smith, Dropleman & Thomas, 1996) have demonstrated personal anger and a negative or toxic work environment for nurses. Anger resulted from work-related experiences which they name as horizontal violence and describe in graphic terms as needling, cutting, blasting, backbiting, pointing out flaws, weakness or omissions in and by other nurses, sabotage (including non-verbal signals), the chilly silence, and damaging gossip (Thomas & Dropleman, 1997). Thomas and Dropleman further identified anger at supervisory personnel predominantly that management failed to support nurses and for authoritarian, fault-finding, uncaring behaviour. Tovey and Adams (1999), in a study of 130 acute care ward nurses in the UK NHS, also identified dissatisfaction to be related to the work environment and in particular with management and the morale of the unit. Robson (1999) depicted NHS nurses’ attitudes to management as being at best that of indifference and at worst contempt for being so inadequate at their jobs.

Other studies within acute care areas also indicate that violence and harassment are both an international problem and an everyday encounter for acute care nurses (Arnetz & Arnetz, 2000; O’Connell, Young, Brooks, Hutchings & Lofthouse, 2000; Rippon, 2000). It has been demonstrated that violence and harassment are under-reported by nurses, particularly emotional abuse and verbal sexual harassment (Duncan, Estabrooks & Reimer, 2000; Farrell, & Bobrowski, 2003; Hegney et al., 2003) with Australian studies estimating 70% of incidents to be not reported and of a culture of silence (Jones & Lyneham, 2001). The Australian studies of Farrell (1999) and O’Connell et al. (2000) demonstrated workplace aggression to be the most anxiety-provoking aspect of nursing work and linked this to recruitment and retention. O’Connell et al. found that 95% of the 209 participants had experienced repeated incidents of verbal aggression in the 12 months preceding the study.
McMillan (1995) and Taylor, White, and Muncer (1999) studied bullying within nursing, which they described as a form of harassment, with the most common perpetrators being nurses to other nurses and with many respondents indicating that they had been bullied for 2 years or more. A further study of nurses found 61% of respondents identified line managers as being a continual source of bullying (McMillan, 1995). Paterson, McComish, and Aitken (1997) also suggested that bullying is predominantly carried out by line managers to their subordinate staff and, similar to other studies (Duffy, 1995; Giles, 1998), described behaviours of excessive abuse or criticism, intimidation, inequitable rostering practices, rumour mongering, blocking opportunities, removing responsibility, threats, ridicule, excessive and/or impossible demands, withholding information, and misuse of power to incite others to marginalise or exclude the victim. A case study (McCall, 1996) also reported perceptions of nurses that middle managers were responsible for horizontal violence within work areas.

Skillings (1992) explored the perceptions and feelings of hospital nurses concerning their experiences of horizontal violence. Utilising a critical feminist methodology with six participants, three of which were nurse managers, she identified structural, organisational, and physician induced oppression for nurses both at the clinical and managerial level. Participants described nurse managers as adopting marginal behaviours, acting like oppressors, and identifying with the dominant culture of medicine and the bureaucracy. Feelings of being over-powered and unsupported were related. Participants reported feelings of separateness, distance, and disconnection. Participants also talked of times when they had found themselves participating in horizontal violence or acting hostile toward a nursing colleague.

The controlling, coercive, and rigid characteristics of leaders in powerless groups, including nursing, has been depicted by Roberts (1983) and the horizontal violence that emanates as a result of being unable to revolt against the oppressor. A trashing syndrome (Gill, 1984; Marriner, 1982) has been noted in nursing and described as a form of character assassination, done to divide women against each other, and to destroy. It is a repressive process that emphasises obedience, compliance, and conformity in patterns of relationships between nurses. Trashing involves public or private manipulation by giving misinformation, interpreting actions in the most negative manner, and it “questions one’s motives, stresses one’s worthlessness and breaches one’s integrity” (Marriner, 1982, p. 12). The queen bee syndrome or antifeminist behaviour in women who have careers in leadership positions is also described by many as existing in nursing (Donnelly, Mengel & Sutterly, 1980; Gill, 1984; Smythe, 1984; White, 1986). According to White (1986) “the Queen Bee aligns herself with males and seeks their approval, while in an attempt to reduce competition, she
requires women who will report to her to perform the traditional female role … but failing to train subordinates or to share her expertise” (p. 45).

Marles (1988) in her study of Professional Issues in Victoria investigated many nursing relationships, however, not that of nursing management. In discussing the role of the nurse manager within acute care she however stated

[Here] was most complaint about the unresponsiveness of nursing management to the needs of the clinical nurses, and of the rigidity of the rules and regulations under which nurses operated …. There was criticism that [senior nursing managers] were sometimes remote and uncaring and did not appear to understand or take into consideration the technical complexities of much current nursing … nurse managers who persist with a managerial style reminiscent of ‘the old army tradition’ … contribute to nurses leaving what they regard as an unacceptably hierarchical and rigid environment. (p. 75-80)

A study of midwives in Ireland (Begley, 2002) also identified hierarchical structures evident in midwifery management, including a lack of respect in relationships and a return of students as staff which ensured a continuation of the hierarchical regime. A subculture of nursing/midwifery subordination is described with the female hierarchy exercising control over other women within a male-based power structure.

Cox (1987) surveyed verbal abuse amongst nursing personnel, finding that 82% of nurses experienced verbal abuse. She concluded that conflicts between nurses and their peers, and between nurses and nursing administrators, contributed more to nurses burning out and leaving the profession than any other factor. Braun, Cristle, Walker, and Tiwanak (1991), utilising the same survey instrument, found similar results with 78% of nurse respondents reporting abuse from physicians, 52% reporting abuse from staff nurses, 24% from immediate nursing supervisors, 21% from subordinates, and 6% from administration.

Nurse abuse has also been documented in research by Gasparis and Swirsky (1990) and Kohnke (1981) who described generational abuse where older head nurses believe they have earned a right to be served due to their own previous mistreatment by nurses. Gasparis and Swirsky attributed nursing shortages to the cumulative effect of nurses being undervalued, their subjection to ancient and pernicious stereotypes, and to being treated with cavalier indifference or crass condescension. They documented horizontal violence that emanates from nurses adopting the masculine values of the health care system and devaluing their own feminine caring values, as well as lack of support and abuse from administrators, doctors, and from nursing administrators. The notion of a toxic environment has been argued by Cullen (1995) and Schlomann (1993) who noted the discourse on nurse burnout to be restricted to a patronising view that identifies the individual nurse as having an illness or
being the problem rather than workplace identified for its forces of alienation and oppression or the system noted for exploitation.

Several studies within the UK have identified that nurses have felt intimidated to speak about professional incompetence and misconduct within the workplace due to concern with personal victimisation and/or being forced out of a job (Commission for Health Improvement, 2000; Commission for Health Improvement 2001; Hunt & Shailer, 1995). This has also been documented in Australia (Armstrong, 2002a) and in a study interviewing thirty whistleblowers (Hunt & Shailer, 1995) that found respondents reported managers as generally ambivalent and hostile to revelations and in some cases were receptive but constrained by their superiors. Gulland (1998) described this as not being able to speak out and being gagged by the structure and hierarchy of the hospital. Faugier and Woolnough (2002) advocated that even with the passing of the Public Interest Disclosure Act 1998 nurses need a more open culture that can only be initiated by leaders capable of challenging the existing social equilibrium.

More recently in Australia the National Review of Nurse Education (DEST & DoHA, 2002) depicted the culture surrounding nursing as discouraging to nurses with hierarchical attitudes among nurses and senior people not always treating more junior staff with an appropriate level of respect. It further reported still to exist in nursing an old-fashioned tendency toward eating their young impacting upon morale within the profession and the way nurses feel about themselves. The Senate Inquiry (2002) within Australia similarly found nurses reported “disillusionment through feeling unappreciated and undervalued for their contribution and commitment, [and they] perceived lack of support from their management” (SCAC, 2002, p. 127). Both of these studies noted that measures to improve the work satisfaction of nurses have been well documented in workforce reports and research but have not been put into common practice. Both studies recommended the inclusion of nurses in the organisational hierarchy to meaningfully participate in decision making and the further development of nurse practitioner roles. The SCAC (2002) also recommended that the current career structure be reviewed and revised to provide career pathways that include continued clinical practice, that recognise clinical expertise and enable practitioners to remain in the clinical setting but still pursue career progression. International and interstate studies have indicated similar problems and have forwarded recommendations to health service managers, including notions that employees should be treated as assets to be nurtured, not costs to be counted (Flannery & Grace, 1999; Robson, 1999; Menadue, 2002).

Alternate models of organising nursing have been advocated where there is an emphasis on transformation of the organisational culture of nursing and alternative structures developed to that of the traditional nursing hierarchy. Variations exist in the literature regarding these
alternate models, however, they include notions such as decentralised decision making (Acorn et al., 1997; Parker & Gadbois, 2000), shared governance (Allen, Calkin & Peterson, 1988; Edmonstone, 1998; Ireson & McGillis, 1998; Jones-Schenk, 2001; Porter-O’Grady, Hawkins & Parker, 1997), professional practice (Massaro et al., 1996; Pierce, Hazel & Mion, 1996), professional governance (Jenkins, 1991) and self-managed teams (Mischenko, 2002). Some of these concepts have been aligned with what are termed the magnet hospitals in the US, that being hospitals noted for an organisational culture and structure that attract and retain nursing staff (Buchan, 1999; Carlowe, 1998; Jones-Schenk, 2001; Kramer & Schmalenberg, 1988). Whilst the models and concepts vary in their application, they contain similarities in their emphasis of a structure of devolved management, shared participation in decision making, and a supportive work culture.

Shared governance and the magnet hospitals have been the most researched with claims of: increased staff satisfaction; good collaboration between nurses, physicians and administrators; increased levels of status and autonomy for nurses; nurse participation in policy decisions; increased retention of nurses; improved patient outcomes; improved patient satisfaction; and excellent nursing leadership (Allen et al., 1988; Carlowe, 1998; Doherty & Hope, 2000; Jones-Schenk, 2001; Ludemann & Brown, 1989; Porter-O’Grady, 1990; Relf, 1995; Robinson, 2001; Scott, Sochalski & Aiken, 1999; Thrasher et al., 1992). Porter-O’Grady (1990) noted that professional staff governance demands a different structuring of the organisation to the traditional nursing hierarchy so that there is a bottom-to-top approach. Several studies attested that the label is not important (Buchan, 1999; Peterson & Allen, 1986; Spooner, Keenan & Card, 1997) as long as there is commitment to an operating philosophy that incorporates and emphasises

- mutual responsibility between individuals incorporating a sense of caring, nurturing, understanding and mutual support;
- cooperative and collegial working relations between staff and disciplines;
- sharing of information that is a two-way process;
- responsibility by leaders for teaching staff how the organisation operates;
- accountability and responsibility for good quality patient care; and
- identification and correction or problems before they shift to higher organisational levels.

These concepts also fit with recent notions of community building advocated within nursing by Parker and Gadbois (2000) who described community building to be a career long philosophy rather than a strategy. Peterson and Allen’s (1986) research advocated that after implementation of a model containing the above characteristics, including supportive leadership, the nursing culture was transformed to be far more humanistic. Veronesi (2001)
reported anecdotally of similar success in producing what he terms a *caring environment* for staff. Jones-Schenk (2001) noted that “the organization’s support of one’s professional values is essential in the workplace as well as the importance of a sense of community … [and] receiving positive recognition” (p. 41). Increased job satisfaction, increased control for nurses over their work environment, and improved patient outcomes have been reported after implementation of models of shared leadership and unit based governance (George, Burke et al., 2002; Pierce et al., 1996). Improved nurse performance and work satisfaction has also been reported following the implementation of decentralised organisational structures and decision making (Acorn et al., 1997; Marshalleck, 1997). Miller (2002) described a restructure to a shared governance approach which she claimed assisted to reduce real and potential conflicts among nurse executives by promoting cooperation, professionalism, and trust. Miller’s premise was that the development of nurse relationships closely relates to promoting and accepting the expression of positive and negative feelings through the sharing of perspectives. Many of the reports in the literature are anecdotal accounts however, describing how shared governance has improved staff morale and outcomes within the author’s respective hospital, directorate, or unit.

Gavin et al. (1999) described a different view of shared governance, asserting it increased nurses’ responsibility and accountability whilst sceptical if it increased their power. Edmonstone (2000) noted that for empowerment and shared governance there must be a true move from the hierarchy and a shared commitment to the winning of hearts and minds involving permission, opportunity, and support. Similarly, Lewis (2000) also warned against managerial practices and attitudes which may mitigate against nurse empowerment asserting that structural changes are insufficient without cultural and attitudinal changes. These views are supported by the second study of UK trusts in the *Principles in Practice* (British Association of Medical Managers, 1996) projects which identified that despite the rhetoric that clinicians should be involved in management decisions within the trusts they were in fact being undermined. Despite nurses often leading and implementing innovative schemes with limited financial resources, they were rarely recognised for their achievements.

Some early studies (Cresia & Parker, 1991; Howard, 1987) indicated doubt about the models of shared governance and the magnet hospitals. A study of work satisfaction in differing work structures (74 acute care wards) by Adams, Bond, and Hale (1998) found that different structures of organising nursing care did not influence staff satisfaction. Wells (1990), in a survey of 137 nurse managers in acute care settings, found that there was no difference between job satisfaction of nurse managers in hospitals where the management structure was decentralised, as compared to nurse managers in hospitals where there was a centralised management structure. Conversely, a Canadian study by Acorn et al. (1997) of 200 first-line
nurse managers concluded decentralisation was the most important predictor of nurse manager satisfaction and organisational commitment, similar to a previous study of 331 nurse managers that reported increased work satisfaction and commitment with decentralisation (Ringerman, 1990). Drayton-Hargrove (1996) compared the leadership behaviours of nurse managers in various structures, including traditional and participatory, concluding organisational structure alone was not a significant influence on nurse managers’ behaviour. Some recent and extensive studies, however, have demonstrated improved work satisfaction, attraction and retention of nurses, and improved patient outcomes, particularly within magnet hospitals (Aiken et al., 2001; Aiken, Havens & Sloane, 2000; Aiken, Smith & Lake, 1994; Miller, 2002; Nevidjon & Erickson, 2001; Scott et al., 1999). Robinson (2001) described the transformation of a critical care work environment within a hospital achieving magnet designation, advocating it to have created a culture among staff that was supportive, collegial, respectful, and friendly. A study conducted by Spooner et al., (1997) also documented high levels of empowerment and accountability for nurses in decision making following a change to a shared leadership model within a critical care unit.

Several authors have noted many organisations to have mislabelled their governance structures. Many have allowed the majority of authority to be retained by managers and administrators (Havens, 1994), whilst others contain few of the shared governance characteristics identified by the experts (Hess, 1994; Hicks, 2003). In a further study, Hess (1995) found clinical nurses rated control over personnel and resources as more important indicators of governance than control over practice or decentralised decision making which is often equated with shared governance.

Summary
This chapter has explored the literature surrounding the social organising of nursing. The literature supports the social and structural organising of nursing to be historically based upon a rigid top down non-professional hierarchy with poor valuing of nursing expertise and practice and poor collegial relations. The work of nurses has been aligned with the natural talents of a woman and has subsequently been viewed as requiring little intelligence and been poorly valued. Horizontal violence, vertical violence between nurses and nurse managers, verbal abuse, and a lack of collegiality have been documented. Both historical accounts and contemporary studies allude to nurses being involved in relations that include bullying, physical and verbal abuse, trashing and queen bee behaviour. A culture of silence, lack of reporting, and inability to gain support from higher levels of nursing who are often reported to be indifferent or support this culture, is noted.
Structurally, the most senior nurse is alone at the top of the hierarchical pyramid and has little professional support, which may be reflected in the literature that documents their rapid turnover. Despite many years of attempted professional recognition, this social and structural organisation is contrary to the structure and social relations normally seen in what may be termed the traditional professions where professional expertise is valued over administrative expertise. Alternate models have been advocated that emphasise greater value on the practice of nursing, valuing individual nurses themselves, decentralising decision making, and on increased collegiality. These historical relations, however, appear difficult to shift. Even the new models still place the value and power of administration or management over and above that of the practice or expertise of the expert clinical nurse.

The literature supports that changing structure, such as decentralised decision making, is insufficient alone and that it must be genuinely incorporated into the valuing of staff and the social relations of the work culture. The social relations of nurses have been shaped by the poor social depiction and value given to nursing as an occupation, the marginalisation of nursing as women’s work and within the hospital division of labour. The current climate of managerialism and economic efficiency further encourages nursing to adopt a non-professional hierarchy and privilege management work over nursing. Whilst leadership has been called for in order to further the professional status of nursing, the very privileging of notions of management and leadership have reinscribed and contributed to the current status, non-professional structure, and poor interpersonal social relations of nursing.
Chapter Five

Literature review

Nurses’ experiences of managing and being managed—

Illuminating the specific lyrics
Introducing nurses’ experiences—*Illuminating the specific lyrics*

This chapter specifically describes the literature that documents nurses’ experience of managing and being managed. Due to a lack of literature specific to the critical care context and that many nurse management roles extend beyond the bounds of critical care, the scope of the literature review is broadened to management experiences within acute care contexts. The first part of the literature review examines nurse managers’ experience of managing nurses including senior, middle, and first-line nurse managers. The literature that depicts nurses’ experiences of being managed is then briefly critiqued, followed by the limited literature that pertains to the context of critical care.

Nurses’ experience of managing—*I am the captain of the Pinafore*

The literature on nurses’ experience of managing is predominantly quantitative with data elicited primarily via survey. Only one study was identified that made international comparisons, and only five studies were identified that utilised an ethnographic methodology. The central interest of most research on nurse managers has focused on identifying the changing roles, characteristics, competencies, leadership activities, and effectiveness of nurse managers. This is a slight move in focus from predicting leadership and leadership effectiveness, which was found to be the major theme in a review by Alteri and Elgin (1994) of the nursing leadership literature. Studies that have focused on nurses’ experiences rarely have been specific to their relations with other nurses and have concentrated on narrations of top level nurse executives or the experiences of first-line managers, sometimes referred to as unit managers or charge nurses. The experiences of staff nurses, associate charge nurses, or those in charge of shifts, and those of middle level supervisory status, have been poorly researched and documented. Most studies of nurse leaders have focused on nurses in formal senior or executive management roles as they appear to be consistently identified by nurses in these studies as the nursing leaders (Manfredi, 1996). Alteri and Elgin (1994) also noted that most leadership literature is of formal leaders and recommended research to explore the leader-follower relationship.

Experiences of senior nurse managers, nurse executives, and chief nurses—

*It’s a long way to the top*

Differences in health care systems (Carroll & Adams, 1994), determination of the role of the nurse manager by the current work institution (Oroviogoicoechea, 1996; Willmot, 1998), plus a lack of research (Duffield & Franks, 2001; Yuen & Tiwari, 1996), confuse global investigations into nurse managers’ roles and experiences. The role of the most senior nurse or nurse executive has been documented to be changing with the corporatisation of health
care (Davidson, 1996) and is reported by senior nurses to have increased in breadth of responsibility (Ballein Search Partners, 2003). The leadership role of the chief nurse, as perceived by chief nurses, is reported in numerous studies to be one of the most important roles of nurse executives (Baxter, 1993; Fosbinder et al., 1999; Sorrentino, 1992a) including one study of 159 chief nurses across five Nordic countries (Henry et al., 1995). Other important aspects of a senior nursing role, as perceived by nurse managers, is that of resource allocator (Baxter, 1993) and resolution of patient care problems (Fosbinder et al., 1999). Law and health care policy, mentoring, balancing cost with quality, and finance have been identified in large survey studies of chief nurses as the functions of their role they considered most important and spent most of their time performing (Ballein Search Partners, 2003; Scalzi & Wilson, 1993). Murphy and DeBack (1991) identified characteristics and competencies of nurse leaders, again as identified by managers, to include managing the dream, mastery of change, taking the initiative, and organisational design. Sorrentino (1992a) identified interdepartmental communication, operational budgeting, and conflict resolution as ideal competencies of a chief nursing executive, but as identified by chief executive officers.

The two most important skills required for leadership effectiveness of chief nurses, as described by chief nurses and chief executive officers, were general management knowledge including finance, and health and nursing knowledge (Henderson, M., 1995). Leadership motivation of chief nurses in this study was identified to be predominantly socialised and personalised, leading to the researchers’ rather scathing summation that chief nurses had a “tendency to seek power for self-agrandizement … create[d] overly dependent subordinates … [and] have a tendency to be impulsive, exploitive and efficiency conscious” (Henderson, M., 1995, p. 50). Dunham-Taylor (1995), however, identified nurse executives who were highly ranked by their staff as leaders to be highly motivated, optimistic, energetic, balanced, striving to improve both personally and professionally, and displaying a quality of humility. Respecting and valuing others efforts, coaching, protecting and growing staff with a humanistic attitude, was also noted.

Despite the importance of chief nurses, the literature questions their inclusion in top level decision making. Byers (2001) conducted a survey of 269 healthcare executives (nursing and non-nursing) in the US revealing nurses had a vote at the governing board level only 8.7% of the time. Providing quality care with declining reimbursement was cited as the major challenge. White (2000) found similar results in a study of seven executive nurses who reported dilemmas of balancing cost and care, attempting to blend expectations and traditions, and of embracing moral obligations amidst ambiguity. Dunham-Taylor (2000), in her study of 396 nurse executives, also reported 9% of nurse executives not to be attending
senior executive meetings and that 20 to 25% were neither included in board meetings nor medical executive committees. Having a seat on the executive board has also been shown to not guarantee influence or inclusion as Cameron and Masterson’s (2000) study displayed nurse executive directors’ roles structured so that there was total devolvement of nursing management to medically defined directorates. Several studies of executive or chief nurses display these nurses’ lack of autonomy and financial authority yet the responsibility of a large budget or budgets that they were accountable for, and that approximated 30% of the total institutions budget (Baxter, 1993; Hodges & Poteet, 1991; Jaco, Price & Davidson, 1994). In a more recent study of 103 senior nursing officers (Ballien Search Partners, 2003), senior nursing officers reported they were now responsible on average for 43% of the total organisational budget, however, one fourth reported poor to good relationships with the chief financial officer.

Dwore et al. (2000) interviewed and surveyed chief nurse executives from 53 acute care hospitals in Utah. Most nurse executives reported good integration into the executive team, however, whilst many nurse executives attended, or reported participating as needed at the governing board, most had no voting powers. Nurse executives reported their integration was largely due to their own initiative and that barriers included the negative stigma of being a nurse and preconceived ideas of gender. Many reported having to work harder, dressing in a non-feminine manner, using male terminology, and working with political games such as pre-meetings to circumvent exclusion where meetings followed the male ethos of announcing a decision rather than making a decision. A study by Wells et al. (1999) identified the more recent promotion of nurse executives to be included within the top management team may threaten the position of other senior administrators within this group. Issues of gender, financial-clinical tension, and organisational culture were also reported as major themes in a feminist study of chief nurse executives (Trhearne, 2000). Dunham and Fisher (1990) noted nurse executives reported the informal old boys’ forum and that they were excluded from what occurred in locker rooms, the golf course and club; those places that were an instrumental part of the power game.

One study interviewed five nurse executives, exploring their utilisation of multiple frames of reference, that is, looking at situations from more than one vantage point (Klenklen & Hoffart, 1995). The study utilised the four frames of Bolman and Deal (1991), that is, structural, human resource, political, and symbolic. It was concluded that whilst the study was small, several nurse executives did utilise numerous frames and this was prevalent in the more experienced nurse executives. Further research was recommended regarding how this framing took place and its links with effectiveness.
Stress, lack of autonomy, and lack of social support has been measured and classified (Hingley & Cooper, 1986) and reported as experiences of chief nurses (Fosbinder et al., 1999; Lee & Henderson, 1996; Scalzi, 1990; Smith, 2002). Hingley and Cooper identified causes of stress to be difficulties in managing the workload, conflicts between staff, inadequate preparation for the current role, conflict between home and work, and dealing with death and dying. According to Cohen (1989), limited social support attributes to the stress of nurse managers, as there is an increasing reduction in the number of peers in ascending the career ladder and an inability to utilise local colleagues as consultants or confidants due to competition. Lee and Henderson concurred in their study of 78 nurse administrators, finding those who reported limited opportunity to meet with other nursing colleagues had higher levels of emotional exhaustion. Studies of role stress (Scalzi, 1990) and sources of dissatisfaction (Fosbinder et al., 1999) of top level and chief executive nurses identified work overload, concern with quality and lack of support, organisational and administrative duties, job insecurity, and lack of recognition to be reported by nurses. Politics and lack of respect for nursing were again reported by 103 senior nursing officers as the major frustrations of their jobs (Ballein, Search Partners, 2003). A Swedish study that interviewed 15 nurse executives reported nurses as describing they had to be thick skinned and that they were more critically scrutinised than their physician manager colleagues (Lindholm, Udén & Rastam, 1999).

Several studies have documented nurse executives as reporting that they achieved executive level management but that it was not without sacrifice (Dunham & Fisher, 1990; Dunham, Fisher & Kinion, 1993; Dunham, Fisher & Snelson, 1991; Dunham-Taylor & Klaufuhn, 1996). In order to commit the time and energy required to network, mentor, build trust, coach, and attend to small details, it resulted for them in a poor balance between work life and home life, with home life suffering. This is also supported in Irurita’s (1994) grounded theory study of 32 nurses in top level leadership positions in Western Australia. Irurita reported nurse managers had to manage from a historical context of retardation or repression (training, low status, medical dominance) that resulted in current nursing mediocrity. A process she described as optimising was utilised by nurse managers to make the most effective and optimal use of resources to compensate for this context and to move beyond mediocrity toward excellence. Nurse leaders were optimistic, exhibited strong values of concern and caring for others including patients, staff, the organisation, and the nursing profession with little self-interest, and demonstrated commitment to client care, to developing staff, and to advancement of the organisation and nursing. Similarly, she found high achievement was desired by nurse leaders, resulting in hard work and long hours with personal sacrifice. Commitment for some leaders was almost fanatical with the giving up of
most other aspects of their lives. Irurita detailed nurse executives’ description of themselves as persistent, determined and reasonably tough, motivated by a desire to right injustices and promote equality. The findings of Irurita are consistent with those of Fralic (1993) who identified characteristics of nurse executives to include having a passion for excellence in patient care, to be caring, confident, and imperturbable. These studies, however, did not examine the relations between nurses and nurse executives.

The literature depicting the high turnover of chief nursing officers was discussed in chapter four. Kippenbrock (1995), in examining turnover, identified the lack of power to make changes as the most frequently reason cited by chief nurses for leaving. Other reasons included conflicts with the chief executive officer, inadequate nursing personnel, a desire for a career change, feelings of isolation, lack of peer support, and loss of personal confidence. Lindholm and Uden (2001), in a Swedish study, conducted two interviews with 27 senior nurses and nurse executives with a three-year interval between interviews. Initially, nurse managers related loyalty as a learned habit in which they obeyed rather than questioned decisions from the top level and discussed concern with their non-acceptance as chiefs by physicians and other professionals. However, in the second interview, greater emphasis was related to supporting and role modelling for the ward managers, as well as the importance of networks outside of the hospital and of significant mentors.

Exciting aspects of a nurse managers’ work was explored by Zavodsky and Simms (1996) who surveyed 399 nurse executives and nurse managers. Nurse executives reported being more excited about their work compared to nurse managers whilst nurse managers, unlike executives, reported enhancement of patient wellness as a contributing factor to their work excitement. Overall, respondents ranked the variety of experiences, personal growth and development, recognition, planning and implementing new projects, teamwork, and challenge as the main factors contributing to their work excitement. Interaction with subordinates, peers, supervisors and physicians, as well as responsibility for patient care, has also been cited as a source of satisfaction for chief nurses (Fosbinder et al., 1999).

Experiences of nurse executives have also been reported from individual interviews, case studies, and in several texts that recount individual nurse experiences and historical biographic analyses (Bullough, Bullough & Yow-wa, 1989; Burchill, 1992; Feldman, 2001; Jeska, 1994; Koerner, 1997). Whilst the narrations differ tremendously, many senior nurses noted the influence and support of significant people early in their lives and careers, that chance or luck played a significant role in their careers, their own personal determination and hard work was essential and often they regretted the sacrifice to their personal and family life. Bullough et al. also claimed many nurse leaders were older than other nurses were when they commenced nursing and had good academic and personal achievements comparative to
men. Redmond (1995) interviewed 10 chief executive nurses also identifying the importance of mentors and of a competitive spirit. Case studies of nursing leaders have been detailed by Jeska (1994) providing a rich descriptive portrait style account of nursing leaders. The predominant focus, however, is toward their effectiveness, their theories, and their transformational attributes rather than their experiences of managing or relations with other nurses.

**Experiences of middle nurse managers—Up on the roof**
Few pertinent studies could be identified specifically investigating middle nurse managers. Human management skills were rated as the most important skill of middle nurse managers (nurses who had 24-hour accountability for three or more patient care units), as reported by chief nursing officers and middle nurse managers (Patz, Biordi & Holm, 1991). Ingersoll, Cook, Fagel, Applegate, and Frank (1999) investigating the experiences of nine midlevel nurse managers, following a work redesign, found these midlevel nurse managers reported expanded role responsibilities, decreased self-esteem, environmental uncertainty, and concerns about the delivery of care. Middle nurse managers, in a survey conducted by Gresham and Brown (1997), preferred high relationship styles of managing. This study of management style and satisfaction also reported a lack of delegating style at the senior management level. Caine and Kenrick (1997) in exploring clinical directorate managers’ views of their facilitation of evidence based practice, noted that whilst they overtly espoused to support research, most were actually inhibiting research due to constraining influences of budgets, their own personal experiences as nurses, and a political managerial orientation rather than a professional focus. Other studies have also noted the espoused support of research by nurse administrators, yet stated there has been little progress in research within nursing administration (Le May, Mulhall & Alexander 1998; Yuen & Tiwari, 1996).

**Experiences of first-line managers, charge nurses, and unit managers—No say in it**
First-line nurse managers or unit managers have attracted further research, including Mintzberg (1994) and Dunn and Schilder (1993) who conducted studies that identified the wide variety of activities first-line nurse managers juggle and the fast pace at which they undertake these activities. Everson-Bates (1992), in an ethnographic study of first-line nurse managers involving extensive in-depth interviews with 16 nurse managers, 2 vice presidents and 4 directors of nursing, described the role of the first-line nurse manager as the arbiter of social reality. Within this role their work involved predominantly processes of social control, resourcing, translating, interpreting, negotiating, and facilitating change. Aroian (1997), utilising everyday critical incidents, also explored the roles of nurse managers. Nurse managers reported traditional roles such as being a hero, problem-solver, staff developer,
coach, and change agent. Implementation of these roles differed according to the life experience rather than length of experience of the nurse manager.

Oroviogoicoecheaa (1996) identified functions of clinical or first-line managers, confirming the functions described by AONE (1992). Role competencies of Australian first-line nurse managers have been studied (Duffield, Donoghue, Pelleteir & Adams, 1993), which identified nurse managers as desiring greater control over financial resources rather than just staffing and, similar to a study by Balogh and Bond (1993), as experiencing some conflict over wishing to maintain a high level of clinical skill. Important qualities of effective nurse managers as perceived by nurse administrators has been investigated and shown to include seeing the big picture, having a good self-concept and a flexible attitude, and the ability to manage conflict (Fosbinder, Everson-Bates & Hendrix, 2000). A study which utilised exemplars of 29 clinical nurse managers described the skills and expertise embedded in their practice as preserving the therapeutic nurse-patient/family relationship, negotiating intradisciplinary and interdisciplinary relationships, resolving conflict, and creating a learning environment (Horvath et al., 1994). Leadership activities of nurse managers also have been researched (Manfredi, 1996) utilising a questionnaire and interviews with 42 nurse managers. The concepts of leadership identified were goals, change, influence, power, growth, mentoring, and vision. Nurse managers reported administrative goals were handed down from administration over which the nurse manager or staff had no control (Manfredi, 1996). The role of the nurse manager was to sell these goals to the staff and to help staff recognise they could have input into how the goals were achieved. Manfredi contended that “consequently their visions for the future are a function of the organization” (p. 312). Selling new policy to ward staff was also described by ward managers in a study conducted in Hong Kong (Wong, 1998). This, however, contradicts the notion of first-line managers as visionary leaders, when the vision is a function of the organisation. Credibility, gaining staff trust and respect, setting high standards, role modelling, being available and highly visible within the organisation, and being honest and fair were also reported as essential elements of nurse managers (Manfredi, 1996).

The important role of first-line managers in translating knowledge of clinical nursing realities into effective decision making and also that of translating organisational policy into practice has been identified in many studies (Brewer & Lok, 1995; Duffield & Franks, 2001; Everson-Bates & Fosbinder, 1994; Oroviogoicoecheaa, 1996). A concern is raised that the role is moving away from providing hands-on care to spending more time on managing (Brewer & Lok, 1995; Duffield, Donnogue & Pelletier, 1996), with managers losing their focus on quality care and clinical credibility in their struggle to establish themselves as managers. Duffield and Franks (2001) further argued expanding the role of the first-line
nurse manager to include non-nursing responsibilities risks that they may be replaced by a
generic manager and their span of control becomes so vast they become ineffective.

Gardner and Gander (1992) interviewed 20 nurse managers regarding their experiences of
transition from a clinician to manager. Managers reported distancing themselves from former
peers, difficulty in resolving problems with jealous, resentful or manipulative subordinates,
and, for several female managers, difficulty working with men in group settings. Willmot
(1998) surveyed 36 charge nurses and subsequently interviewed 9 of these nurses regarding
their perceptions and experiences of their changed role to a ward manager and their
increased management responsibilities following a restructure in the UK. Managers
described they worked longer than the contracted hours and 50% believed the change in their
role to ward manager had been imposed on them with very little consultation. Charge nurses
also voiced isolation from the rest of the ward staff, stated it took them away from the
patients, and said it increased the level of stress they experienced. In addition, 86% described
lack of sufficient time to do all the things expected of them, they now had numerous levels
of meetings to attend, and the role should be designated as supernumerary. Only just over
50% of charge nurses believed they had full managerial control, as decisions were made for
them by senior nurse managers reluctant to relinquish responsibility. Almost 60% of charge
nurses reported a lack of adequate information to do their jobs properly, despite the fact that
66% reported good communication with their senior nurse manager. Training to support the
change in role did not commence until nine months after the nurses had commenced the new
roles. Support from senior nurse managers was cited as inadequate by 56% of charge nurses,
and peer group support was identified as helpful by 69%. A study of 12 nurse managers in an
acute care hospital in Hong Kong (Wong, 1998) reported nurse managers as enjoying the
higher status accorded to a manager and that they had a strong sense of belonging and
ownership of their units. They enjoyed the increased responsibility, the challenge, greater
sense of freedom, enhanced authority, and autonomy, however, they also described
themselves as stressed, frustrated, and overworked which they accepted as part of the job.

The AONE study (Barrett, 1990) identified support from peers as the most satisfying factor
in a nurse manager’s job, followed by nurse executive support and staff support. These
results were also supported in a study of 185 managers (Boston & Forman, 1994), with the
additional satisfying factors of having the power to effect change, a sense of personal
accomplishment, recognition and the dignity afforded a manager, reported. Job satisfaction
has been linked to working in a decentralised management environment by nurse managers
(Ringerman, 1990). Positive feedback, being somebody, and gaining attention was again
reported as a major source of satisfaction for ward managers in a Swedish study of 33 nurse
ward managers (Persson & Thylefors, 1999). Human resource skills of consideration and
people orientation were reported by ward managers to be an important skill, as well as competence, patience, tolerance for stress, and multitasking abilities. Many ward managers also reported they often perceived themselves as too pushy or too weak, avoided conflict, had taken on too many duties and responsibilities, and could not find a balance between their professional and private lives. Dissatisfaction with the role included feelings of inadequacy, taking work home, growing administrative duties at the expense of patient-orientated work, and poor relationships with their clinical directors. Many ward managers reported they had made a conscious choice to identify themselves as managers not as nurses, however, many reported this was not an easy decision as they attempted to keep in touch with their nursing role. Persson and Thylefors (1999) compared their findings with data on clinical directors who were predominantly physicians. Physician clinical directors maintained a greater portion of their time on patient and research-orientated duties and ranked their highest competence to be their clinical competence. Ward nurse managers were more employee-orientated in their use of time and ranking of competence. It was argued, in the study, that physicians were less willing to give up their medical expertise that is a source of their credibility which then enabled them to remain in their career, compared to the nurse managers who viewed themselves as professionally incompetent. This study further postulated that the problem of loneliness of ward managers also resulted from them leaving their nursing role and identity to assume a completely restructured identity, being that of a manager. Physician clinical directors had managed instead an expansion of their roles.

Johnstone (2003) surveyed 1913 nurse managers of all levels in New South Wales, exploring environmental, personal and work related factors related to their turnover and retention. Not differentiating their levels of management, she found approximately 70% of nurses reported changing jobs for positive, personal or professional reasons, including promotion, whilst the remaining 30% which were predominantly private sector managers and more senior nurses, changed jobs due to dissatisfying, distressing, and intolerable pressures. Nurse managers listed dissatisfaction with the work environment, not feeling valued by the organisation, insufficient time to satisfy the demands of the job, too much accountability without the power to act, and too often having to take work home to finish as influences on their job changes. Only 7% of managers reported they would like to quit, which is less than the 10% quitting intention reported in the AONE Study (Barrett, 1990). Similar to Johnstone, the AONE study and Boston and Forman (1994) reported nurse manager dissatisfaction and turnover as being attributed to the complexity of the roles and responsibilities of nurse managers, fiscal constraints, insufficient time to do everything, uncompensated work time, and accountability without authority. Role overload was also reported in a Swedish study of nurse managers by Pederson (1993) and again reported together with a lack of resources in a
more recent Swedish study by Persson and Thylefors (1999). In the later study, approximately 50% of ward managers reported an intention to leave their position, with most not returning to nursing. Ward managers reported not wanting to be one among many nurses and wanting to be special, that they could not return due to loss of professional competence and a belief they would find employment as a nurse difficult due to the perception they would not subordinate themselves. Jennings (1990) found nurse managers, similar to chief nurses, experienced a high level of stress and psychological symptoms, however, it was negatively correlated to years of head nurse experience. Again, lack of social support was implicated which was postulated in the study to originate from being between staff and upper management without the support of either group.

Several studies have identified nurse managers to experience ethical quandaries. These are often not clinical topics that are taken to bioethics committees, rather they relate to a disparity between clinical ethics and organisational ethics (Cooper, Frank, Gouty & Hansen, 2002) and issues of justice between the institution and individuals which are often complicated by politics (Borawski, 1995; Brosnan & Roper, 1997). Curtin (1995a) argued ethical problems of nurse managers are often one of the hardest and most neglected problems of nurse managers. She further argued the context of organisational decision making with misunderstandings, miscommunications, fear, isolation, distancing, overemphasis on the bottom line, demand for expediency, ego incentives, and role responsibility to represent corporate policy, tests autonomous moral agency for managers (Curtin, 1996b). This is supported by the study of Persson and Thylefors (1999) who described ward managers as experiencing conflicts between economic limitations and providing satisfactory care.

In a South African study, Gmeiner and Poggenpoel (1996) surveyed 60 nurse managers. Nurse managers reported difficulty in relationships with diverse others, lack of sufficient group acceptance/support, value conflicts, and difficulty with self-acceptance. Nurse managers detailed fear and insecurity related to escalating violence, mistrust between different racial groups, conflicts with trade unions, poor respect from doctors, frustration with head office, insufficient staff, shortage of drugs, stationary and linen, and lack of mentorship and education. Poor family relations also resulted from work tension and the little time spent with family. Feelings of incompetence emerged from not being able to meet all deadlines and feeling they were out of control. The issue and impact on family relations was also raised in a Scottish study of 158 nurse managers (Ulusoy et al., 1996). In this study, gender was highlighted with almost 60% of senior female nurse managers reporting being single, whilst all senior male managers reported being married.

Several studies have described nurse managers reporting experiences of being perceived by staff nurses as having crossed over into a separate and adversarial camp (Silvetti, 1990), and
of adversarial perceptions of administrator bashing (Blancett, 1992). Silvetti described her experience of receiving abuse from her own staff, physicians, families and from superiors, and the isolation of being the central person to which administration focused while subordinates viewed the position as so removed from their own that camaraderie was not extended. Stress resulted from being in a position to work for fellow nurses who were the recipients of her efforts, yet were often non-supportive and reluctant. She asserted there was a lack of awareness that all levels of management, from the clinical supervisor to the vice president of nursing, share this experience. This echoes the opinion of Humm (1994) who described clinical nurses as perceiving nursing managers and non bedside nurses as pseudo nurses; to be irrelevant and non-essential, and Davidhizar (1992) who described numerous factors contributing to loneliness in nurse managers.

Silvetti (1990) further described a sense of impotence associated with seeing the needs of the staff, however, ultimately being constrained by the bureaucracy. She also described concern with authority residing away from the bedside and patient, creating a bifurcation in the profession. In respect to the head nurse position, she claimed “there is little incentive … to deal with a demanding public, be responsible to arrogant physicians, be held accountable for transcription and nursing errors, and be required to follow and impose on your staff prescribed procedures” (p. 239).

The nature of nursing leadership that supports nurses’ autonomous professional practice was researched by Ferguson-Paré (1998) who interviewed 12 Canadian nurse managers. Emergent themes included personal, clinical and structural support, and recognition of staff as competent, professional, and hardworking. Involvement of staff in decision making was also a theme, although this was hampered by power plays, lack of control, decreasing funds, and quality of care. A holistic approach to people was the last theme, which included demonstrating a personal interest in people.

To ascertain dimensions of nurse manager identity, Westmoreland (1993) interviewed 9 nurse managers. She identified three role perspectives: the nurse self, the nurse manager self, and the career self. The role of the nurse self incorporated giving patient care as a means of connecting with oneself and as a grounding technique, such that being a nurse was a major dimension of nurse manager identity. The nurse manager self incorporated management as a stress that was a cost to their personal health and wellbeing, their family and personal relationships. Nurse managers reported workload and providing high quality care as sources of stress, as well as feeling different from staff nurses and hospital administrators. We and they attitudes held by staff nurses was experienced by nurse managers as a feeling of separation, not belonging, and not being supported. This was exacerbated by what was reported as a belief that nurse managers should not socialise with their staff. Nurse managers
described administration as being mostly concerned with statistics, productivity, and organisational survival, and reported a lack of valuing and recognition of nursing by administration. The career self role incorporated personal growth, feeling they were making a difference, and satisfaction, rather than a series of upwardly mobile positions. Whilst working was central to their sense of self, it did not have primacy over relationships. Westmoreland (1993) concluded by questioning the belief that separation and autonomy are the hallmark of mature behaviour and instead suggested that connection and relationships, which are significant in the role of nurse managers, should be viewed as strength. The interconnectedness of nurses’ careers, professional development, and personal lives is also supported by the research of Glynn, Arndt, Beal, and Bennett (1996) who interviewed 25 female nurses regarding their experiences of change in their careers.

Nurse managers’ experience of development into management positions has been studied with early career influential mentoring or role-modelling experiences reported by managers as significant (Boyle & James, 1990; Parson, Fosbinder, Murray & Dwore, 1998). In a phenomenological study of 15 first-line managers in Finland, Hyrkäs, Koivula, Lehti, and Paunonen-Ilmonen (2003) reported the benefits of a structured peer supervision program for nurse managers, claiming it individually assisted managers with personal and leadership development. However, Foster (2000), who surveyed 22 senior nurse managers in the UK and subsequently interviewed 4 participants, reported that managers perceived the predominant style of their development had been unstructured learning. This has also been supported in an Australian study of nurse managers who reported their development as fragmented and random with learning almost by default (Moran et al., 2002).

This concludes the literature discussing the experiences of nurse managers. The experiences of nurses in being managed by nurse managers now follows.

**Nurses’ experience of management—I’m in chains**

Literature specifically focused upon nurses’ experience of being managed is limited. Only one study was identified that specifically examined personnel satisfaction with management in hospital wards (Kivimäki, Kalimo & Lindström, 1994). Whilst this study specifically identified satisfaction in respect to management, it did not delineate nursing management from hospital management, nor identify nurses from other participating ward personnel. Two studies specifically examined nurses’ experience of nursing management, one in a community context (Traynor, 1999), and the other in respect to how it effected their caring practice (Cara, 1999).

The experience of being managed and the relationship with nurse managers can, however, be elicited indirectly among the vast literature that has focused on nurses’ perceptions of nurse
leader characteristics, attributes, ideal competencies, management style, and behaviour. Studies of work culture, work satisfaction and dissatisfaction, stress, work commitment, and turnover also have included and identified issues of nurses’ experiences. Most studies have utilised surveys as the primary method for data collection, with some surveys being statistically analysed and others utilising qualitative analysis. In order to limit this large scope of literature to that appropriate for this study, the following section briefly reviews acute care nurses’ experiences before a further detailed analysis of the limited literature pertaining to the experiences of critical care nurses.

The preferred or desired characteristics of nurse leaders as reported by nurses has been studied by Meighan (1990) who identified the top quality to be caring, followed by other responses such as respectability, trustworthiness, and flexibility. Scott et al., (1999) reviewed the magnet hospital studies, identifying nurses’ desired attributes of leaders to be the leader was visionary and enthusiastic, supportive and knowledgeable, responsive, highly visible, maintained high standards and staff expectations, valued education and professional development, upheld positions of status and power, maintained open lines of communication, and was professionally active. Differing results were found by Wieck, Prydun, and Walsh (2002) who, in order to anticipate the requirements of an emerging nursing workforce, surveyed 108 young nurses and student nurses regarding their desired traits in nurse leaders. Honest was ranked the highest characteristic, followed predominantly by nurturing traits which were motivational, receptive, positive, good communicator, team player, good people skills, approachable, and supportive. Ideal competencies nurses expected of nurse leaders was researched by George, Farrell, and Brukwizki (2002) who interviewed 29 nurses in facilitated focus groups, identifying the competencies to be vision, communication, expertise, advocacy, valuing staff, image, and team empowerment. Qualities of an excellent head nurse have been researched by Pedersen (1993) who interviewed 16 nurses. The major qualities identified included having a humanistic management philosophy, being skilled at negotiation and conflict resolution, having excellent interpersonal skills, being powerful advocates for nurses and patients, being highly credible, innovative, even tempered, and being able to meet the clinical, professional, and personal needs of nurses.

Leadership styles have been researched (Garrett, 1991; Ogier, 1982), including a survey of 561 nurses (Boumans & Landerweerd, 1993) concluding that nurses were most satisfied (as evident by job satisfaction, experience of meaningfulness, health complaints, and absenteeism) when the head nurse displayed both a social (considerate) and instrumental (structure and production) orientation. Nurses who reported to require extensive autonomy preferred the more social rather than structural style. Moss and Rowles (1997) similarly found, in a study of 623 nurses that, as job satisfaction increased the more nurses perceived
the manager to have a participatory management style that included loyalty, trust, group
problem-solving, and high levels of consideration. A preference for participative
management was also found in a study by Lucas (1991) of 505 nurses who perceived that the
current management style they were experiencing in their nursing unit was a benevolent-
authoritative management style. A participative management style was again identified to
significantly contribute to nurse satisfaction and retention in a study of 358 nurses (Leveck
& Jones, 1996) and of all ward personnel (Kivimäki et al., 1994). A Belgian survey of 645
hospital nurses (Stodeur, D’Hoore & Vandenbergh, 2001) examined the effect of work
stressors and head nurses’ leadership style on nurses’ emotional exhaustion which they
claimed was the first step of the burning out process. They concluded that charismatic
leadership, individualised consideration, intellectual stimulation, and contingent reward were
associated with lower levels of burnout, and leaders perceived as closely monitoring nurses
so as to prevent mistakes generated higher levels of emotional exhaustion. They concluded,
similar to other studies, that it is important for supervisors to provide nurses with emotional
support and to give adequate feedback as lack of social support, autonomy and feedback led
to depersonalisation and emotional exhaustion in nurses (Bakker, Killmer, Siegrist &

Sheridan and Vredenburgh (1978), in a now dated study, examined leadership behaviour of
head nurses by surveying 372 nurses who had been the immediate subordinates of head
nurses. They found the turnover rate was the most important predictor of perceptions of the
head nurse leadership behaviour. This is consistent with a study of Landstrom, Biordi, and
Gillies (1989) who interviewed nurses within 18 months of their resignation, concluding that
the most common factor (85%) that generated fear, anger, and bitterness was conflict
between the nurse and immediate nurse manager. These nurses reported intense emotions,
that often their managers’ hands had been tied, and a deep reluctance to resign, however,
their distress had not been heeded. These findings have also been supported by a more recent
study of ward sisters and charge nurses within nine London hospitals (Allen, 2001).

Work satisfaction of nurses working in acute care areas of hospitals has been researched with
nursing workforce issues a prominent and recurring issue, including two meta-analyses
(Blegen, 1993; Irvine & Evans, 1995). Research has been conducted into nursing turnover
and absence (Gauci Borda & Norman, 1997), job satisfaction, professionalism, and intent to
stay (Boey, 1998; Stamps, 1997; Yoder, 1995), and job strain and satisfaction, performance,
and productivity with increased satisfaction linked to increased performance and
productivity (Sorrentino, 1992b; Varca & James-Valutis, 1993). Matunola (1996) identified a significant inverse correlation between job satisfaction and
burnout, confirming the finding of the meta-analysis of Irvine and Evans (1995) that linked a
negative relationship between job satisfaction and turnover. Poor job satisfaction equated with burnout and turnover. Whilst job satisfaction has been correlated with turnover, a meta-analysis performed by Tett and Meyer (1993) found that organisational commitment was found to have the strongest correlation with actual turnover. Demerouti, Bakker, Nachreiner, and Schaufeli (2000) utilising structural equation modelling, confirmed the relationship between job demands and job resources on exhaustion and disengagement leading to decreased satisfaction and increased burnout among nurses.

Factors affecting work satisfaction and organisational commitment have been researched identifying the importance to nurses of the ability to deliver good patient care and to have good collegiate relationships with co-workers (Cavanagh & Coffin, 1992; Edberg, Hallberg & Gustafsson, 1996; Gaynor, Verdin & Bucko, 1995; Lövgren, Rasmussen & Engström, 2002; McNeese-Smith, 1995; Nolan, Owens & Nolan, 1995; Severinsson & Hallberg, 1996; Thomas & Droppleman, 1997; Wheeler, 1998). Low satisfaction from delivering poor quality care, disempowerment, and alienation have been documented as nurses’ experiences of restructuring (Blythe, Baumann & Givannetti, 2001). Important to nurses is to be valued and respected, to be afforded opportunities for growth and to exercise responsibility (Collins, Jones, McDonnell, Read, Jones & Cameron, 2000; Dolan, Van Ameringen & Arsenault, 1992; Fung-kam, 1998; Koivula, Paunonen & Laippala, 2000; McNeese-Smith, 1997; Wilson & Lachinger, 1994). A small study conducted by Frank, Eckrich, and Rohr (1997) involving in-depth interviews with 7 nurses, identified leadership as the most critical theme in the delivery of quality nursing care. Both Irvine and Evans (1995) and Blegen’s (1993) meta-analyses identified good communication with the nurse supervisor, recognition, fairness, and autonomy to be significant factors in nurses’ work satisfaction. Utilising a healing organisational model, Malloch (2000) investigated and measured job satisfaction, peer cohesion, and employee involvement with 192 nurses employed within a medical center in Arizona. The strongest positive relationship identified was that between supervisor support and staff satisfaction. Further studies have identified nurses’ work satisfaction to be enhanced by a sense of accomplishment and equality (Prothero, Marshall, Fosbinder & Hendrix, 2000), family support (Boey, 1998), and supportive clinical supervision (Clegg, 2001; Butterworth, Faugier & Burnard, 1998; Severinsson & Borgenhammar, 1997; Severinsson & Kamaker, 1999). Positive experiences of supervision have been reported in critical care despite some suspicion of a potential managerialist agenda (Burrow, 1995), and that supervision could be used for disciplinary purposes with choice requested regarding who would provide the supervision (Sexton-Bradshaw, 1999).

Medley and Larochelle (1995) and McNeese-Smith (1995, 1997) identified, via survey, that employees whose managers utilised the transformational leadership behaviours of Kouzes
and Posner (1999) reported higher levels of work satisfaction. Loke (2001) replicated the study of McNeese-Smith (1995) in a large tertiary hospital within Singapore with similar results. Dunham-Taylor (2000) also found similar results of increased staff satisfaction with transformational leadership as reported by 1115 nurses who each rated and described their perceptions of their nurse leader. Morrison et al. (1997) examined the relationship between leadership style, empowerment, and job satisfaction concluding that both empowerment and transformational leadership contributed to nurses’ job satisfaction. In a later study utilising semi-structured interviews with 30 participants who had previously identified high or low work satisfaction, McNeese-Smith (1997) described the behaviours of nurse managers that nurses reported made them feel more or less satisfied. The behaviours important to increased nurse satisfaction were, in order of importance, providing recognition and thanks, meeting nurses’ personal needs, helping and guiding, utilising leadership skills, meeting unit needs, and supporting the team. McNeese-Smith (1997) quoted a participant as stating “my manager greets me with respect, gives me freedom to do my job, and trusts me to put down the right time on my time card when I leave. She’s a very good boss” (p. 49). Behaviours of nurse managers that were reported to cause dissatisfaction were not providing recognition and/or support, not following through with problems, and not helping or criticising when patient care was heavy. According to Ingala and Hill (2001), nurses require a close, personal, and supportive relationship with their manager which includes being sensitive to the stress and emotional risks of nursing. Inability to give good care, lack of support, and problems in relationships between nurses and nurse managers was a major complaint from nurses in a now dated survey conducted by the American Journal of Nursing (Hartley & Huey, 1988), however, it has been further and more recently reported in a study of 1,780 nurses in Michigan (Fletcher, 2001) and a survey of 6,000 US nurses regarding their experiences of nursing following recent health care reforms (Corey-Lisle, Tarzian, Cohen, & Trinkoff, 1999).

McGowan (2001) surveyed 72 nurses from a children’s hospital in Belfast to examine stress and work satisfaction. Nurses self-reported the greatest effect on their job satisfaction to be (lack of) organisational support and involvement. This management-related stress was rated higher than the issue of dealing with death and dying. Similarly, Collins et al., (2000) in surveying 452 nurses who had recently commenced new and innovative roles in the UK (predominantly those of nurse specialist and nurse practitioner), found that whilst their work satisfaction was relatively high, these nurses desired more support from their immediate supervisors, with 29% reporting that they would leave if they could. Hillhouse and Adler (1997) also identified that conflict with other nurses and supervisors was a key characteristic of high levels of nurse burnout. In an Australian study, Brewer and Lok (1995) found trust
and identification with middle managers correlated positively with organisational commitment. Whilst the 478 nurses in this study predominantly reported trust with their unit manager, they did not extend this to the more senior nurse managers who they reported as retaining centralised decision making. Other Australian studies (Considine & Buchanan, 1999; Healy & McKay, 1999) utilising surveys of large numbers of Victorian nurses, have identified high workloads, understaffing, frequent unpaid overtime, and professional interpersonal conflicts to be major causes of work stress and dissatisfaction.

Empowerment is also a concept linked strongly in the literature to nurses’ work experience. Kanter (1993) demonstrated the need for nurses to have a work environment that was structured to facilitate adequate resources, access to information, support, and the opportunity to learn, rather than focus on the individual characteristics of nurses. Kanter also stressed the informal social structures such as alliances with superiors, peers, and subordinates which together resulted in higher feelings of autonomy and greater organisational commitment. Numerous studies have drawn on this work and have linked these concepts with organisational commitment (Wilson & Laschinger, 1994), job strain and work satisfaction (Laschinger, 1996, 2001; Laschinger, Finegan & Shamian, 2001; Laschinger & Havens, 1996), and leader encouragement of autonomy, facilitated participative decision making and expressed manager confidence in employee competence (Laschinger, Wong, McMahon & Kaufmann 1999). These later studies primarily utilised methods such as survey with structural equation modelling whilst Kanter’s (1977) original study combined rich descriptive observation and interview data. Increased work effectiveness and achieving the organisational goals remains a central tenet of these and most staff satisfaction studies.

Studies that have specifically and directly explored hospital nurses’ experiences include a national survey of 1,217 nurses within the US with 62% of the subjects identifying that they worked in a critical care type area (Carlson-Catalano, 1990). Nurses reported they perceived the hospital environment as constraining, there were poor physical conditions, and a lack of management value and support for nursing. Separating the responses of staff nurses from nurse managers, it was identified nurse managers also perceived the environment to be constraining, however, the factors of unmet physical needs and perception of management to be unsupportive was not rated as high by nurse managers as it was rated by the staff nurses. The area of specialty of work showed no correlation to nurses’ perception of their hospital environment or management. Nurses reported that administration viewed nurses as being less important than other healthcare professionals and hindered nurse managers’ ability to help bedside nurses. Nurses perceived that once nurse managers entered management they forgot the objectives of nursing practice and did not perceive professional nursing goals
equal to management goals. Positive aspects of work were reported to be collegiality, changeability, and control over schedule. Studies by Smith et al., (1996) and Davies (1995) similarly display nurses reporting angrily and contumeliously of nurse managers being unsupportive. Fedoruk and Pincombe (2000) described this as the management-service gap or the divide between the bedside and the nurse executive.

Nurses’ experiences were also explored by Briles (1994) who conducted a survey of female workers within the NHS in the UK and identified abusive and manipulative behaviour from nurse managers as an experience of nurses. She described responses from her study of the it girl, where managers had an it to pick on, openly encouraging and facilitating the victimisation of one particular person by the remainder of the staff. This bullying is reported in Australia by Giles (1998). Relations between nurses, nurse managers, stress, and the notion of trust have been researched (Albrecht & Halsey, 1991). This study concluded that a perception of trust by nurses in relationship to nurse managers is enhanced when nurse managers provided ample support, and that nurses who felt supported were more likely to discuss innovative ideas. Extending this study, Peterson, Halsey, Albrecht, and McGough (1995) examined communication between nurses and nurse managers. Similarly to Kennedy, Camden, and Timmerman (1990), they found that in relationships where nurse managers communicated supportive messages and promoted the recipients’ self-worth, nurses reported the highest levels of trust and relational certainty and the lowest levels of stress and burnout. Laschinger, Shamian, and Thompson (2001) also found nurse empowerment and organisational commitment to be strongly related to nurses’ trust in management.

One study failed to support the contention identified in most of the literature that poor social support from unit managers and coworkers increased nurses’ perceived work-related stress (Morano, 1993). Utilising the Norbeck Social Support questionnaire and Nursing Stress Scale, Morano’s results, however, did identify respect or admiration from a nurse manager and tangible aid or assistance from coworkers to be associated with lower perceived work-related stress. The experience of managers communicating feedback to nurses and staff appraisals has been documented to be contentious and experienced by some nurses with mistrust (Goble & Holloway, 1996). Nurses reported that despite looking forward to appraisals, they often received feedback only when mistakes had been made, that there was often a lack of appraisals, and they were not always handled skilfully, with maturity, or by diplomatic individuals who saw them as valued colleagues. Furthermore, these nurses expressed concern that appraisals could be used as a weapon against them and managers could manipulate it to “satisfy a grudge and get back at people” (p. 261). Kivimäki (1996) explored initiating yearly confidential conversations between nurse managers and nurses
finding whilst there was a positive change in the perceived sufficiency of feedback, it did not increase nurses’ satisfaction with leadership style.

Nurses’ experiences have also been researched by Perry (1997) who, through the use of critical incident documentation, identified the main issues in the working lives of nurses related to poor quality patient care and disharmony between nurses and their managers. Perry reported that most incidents involved errors of omission where there was lack of support, failure to intervene, and lack of communication by nurse managers. Attridge (1996) similarly utilised incidents to describe powerlessness experiences of nurses, identifying lack of autonomy, lack of respect and value, and lack of collegial support from peers, administrators, and others. She noted that these incidents are not sanctioned to be reported on patient charts or incident reports and therefore become effectively invisible. Cara (1999) interviewed 16 nurses regarding their personal experiences of nurse managers and how this influenced their caring practice. Cara identified a dialectic of power involving both subjugation and empowerment that was reported by nurses. Subjugation involved obstructive bureaucracy, dissonance of values, perceived abandonment, perceived environmental oppression, and distrust of managers. The opposing force of empowerment included relational dialogue, congruence of values between nurses and nurse managers, promotion of autonomy and creativity, moral ideals, and trustworthiness. Wigens (1997) also found conflict in reports of surgical nurses, although this was between the scientific discourse of increased throughputs and efficiency and the new nursing discourse of individualised care. She concluded that nurses coped with this conflict by attempting to rationalise the situation, by keeping the problem to themselves, and/or blaming managers and the Trust.

Nurses’ experiences of collegiality and social cohesion—*I’d like to teach the world to sing in perfect harmony*

Studies of collegiality among nurses has rarely extended to the relations of nurse managers except for studies that examine nurses’ perception of their environment, including antecedents such as stress, structure, and leadership style. According to Curtin (1995b), the collegial relationship is a human relationship, therefore nurses’ mutual humanity forms the fundamental framework for relationships. Hansen (1995), in a study conducted within the US, surveyed 539 nurses from 47 acute care work units defining collegiality as non-hierarchical relations, group cohesiveness, interpersonal exchanges, collaboration, coordination, and cooperation in decision making. Her results indicated the most common factor that promoted collegiality was *substantive exchange*, defined in the study as the degree of give and take among coworkers of valued work-related, social, and personal benefits (rewards of interaction). In an informal survey of 300 nurses regarding nurses’ friendship, Harris, Ryan, and Belmont (1997) reported that many nurses perceived their
friendships with other nurses to be enduring, non-superficial or intimate, and like a special or unique bond. This was attributed to sharing experiences, the intensity of nursing work, having learnt to rely on each other, the type of person that practices nursing, and that nurses were predominantly women. Gaynor et al. (1995) in a study of nurse morale and satisfaction, found a unit culture of social cohesion could be fostered by managers who actively developed and facilitated opportunities for social support. The US Nursing Knowledge Project (1986) also demonstrated that, when facilitated, collegiality among nurses even at differing levels of the hierarchy could be fostered and increased (Gorman & Clark, 1986). This three-year project which engaged nurses in change, strengthened collegiality, and increased administrative sponsorship reported that following the project many nurses viewed even the most senior nurse administrators as colleagues rather than employers. Higher levels of group cohesion have also been reported by nurses who perceived a participative management style to exist in their work area (Leveck & Jones, 1996).

In a critical ethnomethodological study of women’s constructions of collegiality among nurses within a clinical setting, Cash (1998) identified ward relationships and friendships that grounded the care nurses delivered. Nurses described friendships that strengthened within the study, of looking out for one another, seeking each other’s counsel, sharing intimate aspects of their professional lives and day-to-day concerns, caring for one another in ways that extended beyond mutual respect to a bonding that resonated a sense of intimacy and a deep sense of trust. The focus, however, was on nurses, not specifically nurse manager relations.

Chaboyer, Najman, and Dunn (2001) studied cohesion among Australian nurses comparing bedside and nurse clinical leaders’ perceptions as well as critical care and non-critical care nurses’ perceptions. Surveying 555 nurses they found both bedside and clinical leader nurses perceived nurses on the units worked well together, however, some negative perceptions also existed (slightly more by bedside nurses). Overall, nurses perceived a moderate amount of cohesion. This was slightly less than the cohesion reported by Adams et al. (1998) in a study of British nurses from 74 acute care wards, excluding critical care areas. These two studies found the area of work, that being critical care versus non-critical care (Chaboyer et al., 2001), and the structure of nursing care delivered, centralised, two tiered, or devolved (Adams et al. 1998), did not relate to nurses’ perception of cohesion. This is contrary to two earlier studies (Dear, Weisman, Alexander & Chase, 1982; McCloskey, 1990) that identified critical care nurses to have higher work satisfaction than nurses working in non-intensive care areas attributed to increased autonomy and better peer relations. The culture within the specific work environment has also been demonstrated to be more important to how staff perceived their work than the organisational mode (including primary nursing) or staff grade
of the nurse (Thomas, 1992). Nespoli (1991) also found nurses reported a positive-leader-follower relationship to arise from a leader’s creation of a positive work environment, an individualised relationship, and demonstration and maintenance of the leader’s professional competence.

One study was identified that most closely approximated this current study in examining nurse management relations. Traynor, (1994, 1999) specifically examined the relations between nurses and management in four community NHS trusts. This study, utilising a postmodern methodology and deconstructive discourse analysis, identified multiple subject positions of the participants. Managers (nurses and non-nurses) reported nurses to be irrational, fearful, traditional, self-interested, indifferent to change, have a limited perspective, and engaged in frenetic unreflective activity like headless chickens. Nurses reported managers in us-them oppositions and described managers as being too theoretical and out of touch with reality, as being concerned with money rather than care, and that they had little understanding of the complexity, issues involved, or sheer volume of nurses’ work. Traynor concluded that both groups relied on dualistic terms to support their discourses and the discourse of caring as a self-sacrificial moral activity was utilised by nurses to resist managerial discourse of efficiency and rationality. Managers lower in the hierarchy and with a nursing background spoke from multiple, often contradictory, positions including that of wearing their nurse’s hat. Subject positions identified of nurse managers included acting in the public interest, manager as therapist, revolutionary, transparent, and professional. Subject positions for nurses were not identified. The study was offered as “a gesture of solidarity with those who suffer … under regimes of control … [and] as a waging of war on totality” (Traynor, 1999, p. 176).

**Critical care studies—What about me?**

Research or scholarly literature could not be identified that directly examined critical care nurses’ experience of nursing management and only two studies were located regarding nurses’ experience of managing critical care nurses. A prior review of the literature examining stress in the ICU noted the focus of published literature to center on clinical and psychological stress in intensive care rather than organisational stressors (Corr, 2000). The literature specific to critical care, however, includes studies of critical care nurses’ work satisfaction, dissatisfaction, retention, stress, and empowerment which frequently includes or alludes to aspects of nursing management. To a more limited extent, however, and more recently, critical care nurses’ experience of their work environment or work culture has been explored in several studies. These two indirect sources have provided some critical care specific information approximating the topic and informing this review.
Numerous studies have investigated factors influencing job satisfaction and burnout, particularly in specialty nursing units (Freeman & O’Brien-Pallas, 1998) and job satisfaction, stress, wellbeing, burnout, and retention of nurses in critical care units (Alspach, 1998; Baguley, 1999; Bailey, Steffen & Grout, 1980; Bartz & Maloney, 1986; Cartledge, 2001; Clarke, Mackinnon, England, Burr, Fowler & Fairservice, 1999; Cole, Slocumb & Mastey, 2001; Corr, 2000; Cronin-Stubbs & Rooks, 1985; Cronqvist, Theorell, Burns & Lützén, 2001; Dear et al., 1982; Dracup & Bryan-Brown, 1999; Erlen & Sereika, 1997; Goode & Rowe, 2001; Harris, 1984; Huckabay & Jagla, 1979; Kaye, Donald & Merker, 1994; Lau, Chan & Chan, 1995; Le Blanc, de Jonge, de Rijk & Schaufeli, 2001; Norbeck 1985; Robinson & Lewis, 1990; Sawatzky 1996; Stechmiller & Yarandi, 1993; Stone, Jebsen, Walk & Belsham, 1984; Sundin-Huard & Fahy, 1999; Toscano & Ponterdolphi, 1998; Turner & Ogle, 1999). These studies predominantly utilised surveys and inventories to measure reported aspects of nurses’ work experiences, with only a few studies utilising individual or focus group interview methods to elicit data.

Many studies have focused on a variety of factors affecting the experiences and work satisfaction of critical care nurses, such as the experience of unsuccessful resuscitation (Isaak & Paterson, 1996), problems with rapid decision making (Bucknall 2000), caring for brain dead patients (Pearson, Robertson-Malt, Walsh & Fitzgerald, 2001), and ethical decision making (Erlen & Sereika, 1997), rather than focus specifically on the relations between nurses and nurse managers. Most studies, however, have demonstrated a high level of stress reported by critical care nurses including such things as bullying and sexual harassment (Alspach, 1998; Corr, 2000; Kaye et al., 1994; Sawatzky, 1996), and have documented problems of a lack of career path, lack of adequate staffing levels (Alspach, 1998; Bailey et al., 1980; Cronqvist et al., 2001; Gardner & Pierce, 2002; Huckabay & Jagla, 1979; Lau et al., 1995; Norbeck, 1985; Turner & Ogle, 1999), and high levels of burnout and attrition (Sawatzky, 1996). Norbeck reported the level of psychological distress in female critical care nurses to be clinically significant, with 10% of the 180 study participants scoring equivalent to the mean for female psychiatric outpatients.

Attempts have been made to quantify the attrition rate of nurses from critical care units, however, these studies have demonstrated that whilst turnover or attrition appears to range from just over 18% to in excess of 30% a year in Australian critical care units, there is generally a lack of consistent and reliable data available (Cartledge, 2001; Crockford, 1989: Dear et al., 1982; Mathews & Campbell, 1990; Meijs, 1992; Williams & Clarke, 2001; Williams et al., 2001). The relationship between turnover and intensive care nurse hardiness has been studied (Wright, Blache, Ralph & Luterman, 1993). This study suggested a relationship between hardiness (defined as a personality trait characterised by beliefs of
personal control, commitment, and desire for challenge) and stress and burnout, recommending that hardiness be promoted in intensive care nurses.

Whilst critical care areas are often denoted as stressful, the nurses employed in medical-surgical units in the study by Leveck and Jones (1996) perceived higher levels of job stress than those reported by nurses working within ICUs. This supports three earlier studies (Boumans & Landerweck, 1994; Chiriboga & Bailey, 1986; Cronin-Stubs & Rooks, 1985) that also indicated the work environment of an ICU was not more stressful than non-ICU nursing work environments. Blanchfield and Biordi (1996) also found, in a survey of 511 nurses, that those nurses who worked in an ICU or emergency type unit had a significantly higher level of perceived authority compared to nurses who worked in other specialty units, however, there was no difference in perception of authority between nurses working in medical-surgical units and nurses working in ICU and emergency units. This also confirms an early study of Dear et al., (1982) concluding job satisfaction and turnover rates for ICU and non-ICU nurses were comparable, and problems which led to job dissatisfaction and turnover relate to hospital nursing per se rather than to the ICU setting. It appears the relative volume of research within critical care areas may reflect this area as a privileged or popular focus relative to other less technological areas. The lack of research studies in other areas and the results of research that has been conducted (Sawatzky, 1996) do not conclusively support critical care areas as being the most stressful area of nursing work but indicate unit specific variance.

Frequently studies of critical care nursing satisfaction and other similar studies report relations with administration as one aspect or variable factor without specifically differentiating nursing administration from other hospital administration. Two large international studies of ICU management have shown a strong relationship between good communication, culture, and leadership and conflict management to lower risk adjusted length of hospital stay, lower nurse turnover, and heighten technical quality of care (Reis Miranda et al., 1998; Shorten et al., 1994), but again the specific relations of nurses to nurse managers had limited focus. A reduction or shortage of registered nurses has also been shown to directly result in negative outcomes for patients and staff within ICUs (Tarnow-Mordi, Hau, Warden & Shearer, 2000). The American Association of Critical Care Nurses Demonstration projects found good coordination and collaboration strongly linked with nurse satisfaction, however, little emphasis was placed on nurse-nurse manager relations (Mitchell, Armstrong, Simpson & Lentz, 1989).

Whilst fewer studies have been conducted examining positive experiences of critical care nurses, studies measuring nurse satisfaction and intent to stay in critical care have frequently reported it as associated with giving good quality care (Bailey et al., 1980; Le Blanc et al.,
2001; Shannon, Mitchell & Cain, 2002). A study of 814 nurses working in Finnish ICUs identified job autonomy and social respect as important (Suominen, Leino-Kilpi, Merja, Doran & Puukka, 2001). Unit management issues are frequently cited as the most important factor including participative management (Boyle, Bott, Hansen, Woods & Taunton, 1999; Darvas & Hawkins, 2002; Leveck & Jones, 1996; Stechmiller & Yarandi, 1992), and good working relations with medical staff and rostering practices (Darvas & Hawkins, 2002). Other factors identified and ranked as highest sources of satisfaction by critical care nurses are knowledge and skills (Bailey et al., 1980), good interpersonal relationships and group cohesion (Bailey et al., 1980; Boyle et al., 1999), and opportunities for advancement (Stechmiller & Yarandi, 1992). Individualised and sound interpersonal relationships are reported frequently as important to the work experiences and work satisfaction of critical care nurses. Increased work satisfaction and positive experiences have also been related to clinical supervision and mentoring by an experienced critical care nurse (Ecklund, 1998; Pyles & Stern, 1983; Sexton-Bradshaw, 1999).

Studies documenting the implementation of shared leadership, shared governance, and professional practice models into critical care units (Cone, McGovern, Barnard & Riegel, 1995; Reif, 1995; Robinson, 2001; Spooner et al., 1997; Williams, Sims, Burkhead & Ward, 2002) have identified increased staff empowerment, accountability, and partnership in decision making. However, they have acknowledged limitations in respect to the timing of the research following implementation of a changed management philosophy, the size and generalisability of the studies, and potential for bias in reports from participants. The difficulty of creating unit-based change with lack of recognition of the elected professional practice council and with the remainder of the hospital retaining its original structure, was noted (Reif, 1995). The simultaneous introduction of other measures, such as use of unlicensed personnel and increased nurse-patient ratios, also suggests that the name given to the change in management philosophy may have an economic basis and not reflect how it has been otherwise interpreted in the literature.

Several studies, many of which utilised interview format, specifically denote relational problems between critical care nurses and nurse managers and a lack of support from nursing administration (Bailey et al., 1980; Cartledge, 2001; Cox, 2001; Dracup & Bryan-Brown, 1999; Gardner & Pierce, 2002; Goode & Rowe, 2001; Huckabay & Jagla, 1979; Sawatzky, 1996; Sundin-Huard & Fahy, 1999; Suominen et al., 2001; Turner & Ogle, 1999). In an Australian study by Gardner and Pierce, concern was expressed that nursing management is driven by executive management, particularly in respect to budget and fear of job loss. Numerous studies have also identified that environmental and management issues are reported as more stressful than the nature of critical care nursing work inclusive of rapid
decision making and issues of death and dying (Goodfellow, Varnam, Rees & Shelly, 1997; Turner & Ogle, 1999). The study of Sawatzky does, however, identify the unnecessary prolongation of life to be rated by critical care nurses as one of the highest sources of stress.

Environmental and management issues identified in the literature include inappropriate staffing and work load (Alspach, 1998; Bailey et al., 1980; Cronqvist et al., 2001; Huckabay & Jagla, 1979; Norbeck, 1985; Robinson & Lewis, 1990) an inadequate physical environment and resources (Norbeck, 1985; Sawatzky, 1996) and poor interpersonal relationships (Cartledge, 2001; Goodfellow et al., 1997). Feeling unvalued, unrewarded and lack of a career path, autonomy and participatory or decentralised decision making, are also significant findings of research studies (Cartledge, 2001; Cronqvist et al., 2001; Erlen & Sereika, 1997; Freeman & O’Brien-Pallas, 1998; Gardner & Pierce, 2002; Lau et al., 1995; Robinson & Lewis, 1990; Sawatzky, 1996; Stechmiller & Yarandi, 1992; Suominen et al., 2001; Turner & Ogle, 1999). It is asserted frequently in these studies that environmental and management issues can for the most part be corrected by nursing management.

The effects of manager leadership characteristics on nurse retention in four ICUs was studied by Boyle et al. (1999) utilising casual modelling. Surveying 255 nurses who were immediate subordinates of head nurses and accessing hospital data for turnover and unit separation rates, they concluded that manager leadership behaviours emerged as the target for intervention most likely to improve nurse retention. Nurse perceptions of their manager as exhibiting consideration (the degree to which the manager regards the comfort, wellbeing, status, and contribution of staff) and their influence over work activities including information sharing, were directly linked to retention. This study also noted managers were relatively inexperienced and were managing nurses who, whilst slightly younger, had similar levels of professional experience. Lack of nurse manager support was also reported in a study of moral distress, advocacy, and burnout of critical care nurses (Sundin-Huard & Fahy, 1999) which concluded lack of support to advocate for patients and use of nurses as scapegoating leads to further moral distress and burnout in nurses.

Several non-Western studies have explored the experiences of intensive care nurses. An Africaan phenomenological study of five nurses’ experiences of working in an adult ICU (Pope, Nel & Poggenpoel, 1998) highlighted international differences experienced by nurses. The five nurses within the study comprised the total registered nurse contingent of the unit with the unit manager being the researcher and primary author of the study.

Work-related spiritual and emotional distress was experienced by the registered nurses nursing in the intensive care unit. The major themes that emerged were: impaired communication between management and the nurses, racial discrimination in the workplace, lack of professional recognition of nurses via
lack of equitable and competitive remuneration and insensitivity to their professional needs, a depersonalised physical environment and an emotionally and spiritually stressful working environment.

(Pope, Nel & Poggenpoel, 1998, p. 35)

The study concluded with guidelines to support the intensive care nurses. Lau et al., (1995) explored stressors as perceived by 80 nurses working in an ICU in Hong Kong. Inadequate staffing was ranked as the highest stressful factor, which was followed by poor benefits, no opportunity for advancement, and lack of knowledge and skills. The study noted the results differed to many previous studies in that interpersonal relations were not identified as a significant factor.

Only two published articles could be elicited in the literature that pertained specifically to critical care managers, with one study being an empirical study and the other a personal narration. Keene, as cited in Gray (2003, p. 400), described her transition from a registered nurse to the nurse manager of an ICU. She described feeling totally lost, that former friends could no longer be friends, and that coworkers became her employees. She further described being viewed differently even though she was the same person, and that she realised she could not make changes without a struggle. Ohman (2000) utilised a multifactor leadership questionnaire to survey and measure transformational and transactional leadership behaviours of 240 first-line critical care managers. The survey concluded the managers self-rated themselves higher on transformational leadership than transactional leadership, that high ratings in one style of leadership correlated positively with high scores in the other style, and critical care managers with previous leadership experience rated higher than those without leadership experience (Ohman, 2000). Furthermore, in this study, critical care managers reported demonstrating more transformational leadership than nurse executives, chief and associate chief nurses, and mid level administrators documented in previous studies. For an empirical study, however, the research had numerous limitations in respect to the response rate and the specific sample, as well as the self-reporting nature of the study participants.

The physical work environment of critical care units has been explored including discussions of designing a new unit (Williams, 2001), and measures such as noise control, lighting, colour coordination, music, and aromatherapy to make the environment more humanistic and healing (Fontaine, Briggs & Pope-Smith, 2001). These studies however focus on the needs of the patient and family with very small reference to the requirements of nursing staff. Benner (2002) however noted the importance of institutions that foster and support the social space for effective compassionate communication to develop the capacity for individual agency and autonomy. She further noted some recent research conducted within intensive
care that found nurse interventions had no effect on outcomes, omitted to include as outcomes the emotional and affiliative capacities of nurses that occur in sentient moral spaces and that are ends in themselves. Creating a healthy work environment for staff that includes the culture and tone of the work environment, creating a sense of a team and the importance of staff relations and morale within critical care, has been documented (Disch, 2001) but with limited attention, particularly in respect to nurse and nurse manager relations.

**Summary**

In reviewing the literature, a lack of specific studies investigating the relations between nurse managers and nurses in critical care areas was established. Broadening the search to include nurses’ experiences of being managed and managing within acute care contexts again revealed scant literature, however, studies pertaining to topics such as nurse satisfaction and dissatisfaction, stress, excitement, turnover, perceptions, and preferred management style provided a source from which some information could be elicited. Most studies were survey based and measured aspects of nurses’ experiences. The fragmentation of this information does not equate with substantial in-depth accounts of the totality of nurses’ experiences, nor does it account for the many aspects of nurses’ experiences likely to have not been amenable to being measured.

The literature pertaining to nurses’ experiences of managing is mainly opinion-based, with nurse managers usually identified as being leaders. Studies primarily included nurse executives, chief nurses, or first-line unit managers, with research of middle managers in nursing almost absent. Major themes emerging from the literature included the lack of inclusion of nurse executives in top level decision making and the high turnover of these positions. A lack of autonomy, financial authority or power to act despite vast responsibility and accountability, also emerged. Long work hours, excessive demands, and lack of time were reoccurring issues impacting upon nurses’ home and social life. Issues of gender included high scrutiny, playing and talking male ethos, stereotyping, and exclusion. Lack of social, peer, and higher management support, as well as feelings of loneliness and isolation, frequently recurred in the literature. Other issues arising in the literature included loss of identity as a nurse, ethical issues and adversarial perceptions, particularly by clinical nursing staff. Two studies pertaining to experiences of critical care managers depicted high levels of transformational leadership self-reported by nurse managers and the difficulties of one nurse in her transition to a critical care nurse manager.

Literature pertaining to nurses’ experience was also found to be predominantly quantitative. Overwhelmingly, nurses reported positively of their experiences of being involved with the delivery of high standards of quality patient care and that they became stressed and
dissatisfied if this was perceived to be compromised. Nurses also reported positively of supportive superiors and negatively of a lack of this support. Support included being respected and valued, being given individualised consideration, recognition, and positive feedback. The vast majority of the literature supported that this was not occurring. Whilst studies from some countries indicated strong issues of racial discrimination, issues of abuse, bullying, and disregard were reported frequently internationally as nurses’ experiences. The unit work environment or culture was also important, inclusive of a sense of autonomy, participative decision making, good interpersonal relationships with other staff, a sense of collegiality, and social cohesion. Nurses’ experiences of management regarding this work environment or culture identified as particularly dissatisfying or distressing included a lack of the previous listed positive aspects, high workloads, understaffing, unpaid overtime, and interpersonal conflicts.

The results of research pertaining to critical care nurses’ experiences are similar to that of acute care nurses’ experiences. This is attributed to the fact that the issues raised by nurses relate predominantly to organisational and management issues rather than issues of their specific work role. Two additional concerns of nurses were identified in critical care specific studies, that being rostering practices and lack of opportunity for advancement. Whilst these were identified to be poor experiences of critical care nurses, they were not identified as primary concerns.

Similar to the findings of Alteri and Elgin (1994), the literature reviewed in this study indicates human factors such as consideration and genuine interest in staff members were extremely important to nurses. This extended also to nurse managers. Despite this, most literature indicated poor relations and often hostility between nurses and managers, including a culture of *us and them*. The term *connectedness*, utilised in one study (Westmoreland, 1993), conveyed perhaps the most significant aspect of what nurses reported they wanted and that was instrumental to them, and yet considered it was missing in their experiences of both managing and being managed.

Whilst several studies were of women, few studies could be identified that utilised a feminist methodology. Critical or postmodern perspectives were equally scarce with one postmodern study (Traynor, 1999) identifying hostile and conflicting discourses between nurses and nurse managers, however, within a community context. Traynor asserted the hostility arose from the dissonance of these discourses and that nurses were resisting management discourses espoused by managers.

Drawing together the literature reviewed from this chapter, and that of chapters three and four, it can be summated that dominant instrumental and patriarchal discourses evident in the organisational literature and nursing texts construct knowledges and understandings of
nursing management. Definitions of management and leadership are largely uncontested, instrumental, and patriarchal with power relations being poorly considered. The social relations of nursing have been shaped by the poor social depiction and value given to nursing as an occupation, the marginalisation of nursing as women’s work, and within the hospital division of labour and the current climate of managerialism and economic efficiency. Hierarchical, non-collegial relations have resulted with nursing privileging and valuing the work of management above the work of nurses.

Literature that specifically investigated nurse experiences of managing and being managed is informed by dominant discourses reflected in the predominance of quantitative methods of inquiry, assumptions regarding management, and lack of space for nurses to speak of their experiences. Research pertaining to nurses’ subjugated knowledges and discourses of nursing management, and how these practices shape the multiple subject positions adopted by nurses, is absent. The literature that could be identified pertained predominantly to acute care nurses and displayed poor experiences for both nurses and nurse managers in their relations. The experiences of nurses in being managed and in managing nurses within critical care areas has had limited investigation.

This chapter has reviewed the literature specific to nurses’ experience of managing and being managed, including the limited literature in respect to critical care. Being the final chapter of literature review, it concludes by drawing together and summatizing the findings from chapter three, four and five. The following chapter, chapter six, explores and describes in detail the specific theoretical framework utilised within this study.
Chapter Six

Theoretical framework and methodology—

*Composing the score*
Introducing the theoretical framework—*The score*

*Theory is too often used to protect us from the awesome complexity of the world.*

(Lather, 1991, p. 62)

For the purpose of clarity, this research may be best described as a critical ethnography. The methodology employed, however, draws upon and adopts concepts from several major theoretical stances or tenets, which are combined to provide the research framework. Whilst critical social science is core or central to the methodology, feminist and postmodern notions are also significantly incorporated. The combination of perspectives counters some of the limitations of critical social science and creates a framework appropriate to address the research question. No singular theoretical perspective permitted this depth or freedom. Utilising the postmodern notion of nonunitary or mobile subjectivity (Ferguson, 1993, the thesis is represented or authored from the position of multiple, fluid, merging, and sometimes conflicting subject positions. The subject positions adopted to represent this ethnography are those of critical social science, feminism, and postmodernism, however their categorisation is what Trinh (1989) would term *leaky*. This blend of perspectives was not approached without fear of becoming theoretically inconsistent. Nevertheless, I was reassured by Wolcott (1994) who advocated a fear of inconsistency and not getting it wrong causes us to *stiffen* our ethnographic writing. Savage (2000) also suggested, rather than providing a unified ever-more refined version of reality, the use of multiple perspectives helps to elucidate alternative interpretations which might otherwise escape consideration. Cheek (1995) noted understanding representations of “nursing is enriched if it is informed by multiple viewing positions and even, at times, contradictory notions of reality” (p. 239). An alternate name for this blend of methodology would have been to label it as an *integrated feminist postmodern* study (Glass & Davis, 1998) or a *postmodern critical ethnography*. I believe the apportionment of theoretical input tips the balance towards a critical undertone. Readers may gauge for themselves which title may more correctly fit this study as it is but a narrative or text and “intellectual work … generate[s] texts about texts, regardless of the particular metalanguage or rewrite and parsing rules used” (Luke, 1997, p. 346).

Each theoretical position within this blend significantly contributes towards my worldview, reflecting my personal values, epistemology, and ontological position. These theoretical positions, like myself, are not static and have evolved and changed over time (Lincoln & Guba, 2000). They were each chosen and incorporated because they both reflect my personal worldview and methodologically and philosophically fit with my research purpose/question. As a participant researcher and author of the research I do not apologise for my complex and
multiple subjectivity but aim to illuminate and describe fully the theoretical influences that
underpin and have been brought to this research. The method one chooses ought to be in
harmony with the deep interest one brings to the research in the first place (Van Maanen,
1995). To ignore the multiple concepts and to narrow the theoretical base to one convenient
boxed theory would have been to deny the influence of significant bodies of literature that
have shaped the written text. Furthermore, illuminating the ways the investigator’s values
enter the research can lead toward a self-critical perspective and self-reflexive research
paradigm (Lather, 1991). According to Alvesson and Sköldberg (2000),

there is no such thing as unmediated data or facts, these are always the result of
interpretation which does not take place in a neutral, apolitical, ideology free
space. Various paradigms, perspectives, research and other political interests all
bring out certain interpretation possibilities, at the same time as they suppress
others. (p. 9)

In order to explore nurses’ experiences of being managed and of managing other nurses, I
required a methodology that would not only make space for participants to speak, but also to
critique, contextualise, and seek out what was not voiced, including the power relations
embedded in the nurses’ experiences. As such, I spent some considerable time grappling
with various methodologies and arrived at the position of a critical methodology that
incorporates some feminist and postmodern concepts. This version of critical methodology
shares many commonalities with some affirmative feminist postmodern studies. This blend or
integrated position was then congruent both with my personal views and my desire to
describe and make space for nurses to speak of their experiences. The integration or
connection of multiple theoretical positions provides for strengthening of modes of enquiry,
progresses nursing knowledge from dogmatic adherence to traditional methodologies (Heath,
1998; Lincoln & Guba, 2000; Rodgers, 1991), and can reduce the limitations inherent in
singular paradigms (Agger, 1993; Best & Kellner, 1991; Glass & Davis, 1998; Monti &
Tingen, 1999; Sawicki, 1991). Furthermore, a critical appropriation of postmodernist social
theory is a crucial challenge of contemporary critical theory (Morrow, 1994).

This chapter primarily is a theoretical explication where I also endeavour to give reason or
rationale for my theoretical choices, comment on some of the current debates, and depict
some conceptual struggles with which I grappled. The three theoretical positions and their
major concepts are each initially discussed separately. The integration of these positions,
including the tensions and border issues between paradigms, is then discussed, concluding
with the notion of a nonunitary or mobile subjectivity. Chapter seven describes the method
of how this research was conducted, including elaboration of my interpretation and
application of ethnography.
Theoretical overview—Overture of the script

The major theoretical influences within this study are that of critical theory or critical social science, postmodernism, and feminism. Critical social science is perhaps the largest contributor to this study with the social agenda of an intent through the research to create change. A critical model is critical in that it extends upon interpretivism and analyses social situations to determine features which may be altered in order to eliminate certain frustrations or oppression its members are experiencing and empower these members to transform this social order (Fay, 1975, 1987, 1996). Critical social science is my preferred terminology as it incorporates and is inclusive of many varieties of social science (Fay, 1987, 1996), rather than just denote the critical researchers of the Frankfurt School. Feminism may be described as one critical theory of critical social science. Habermas delineated critical social science from critical theory in that a critical social science goes beyond critique to critical praxis: a dialectical process of reflection and political struggle (Carr & Kemmis, 1986). Further elaboration of critical social science follows later in this chapter.

Feminist theory is not listed as the second major influence due to my personal weighting of its value, but rather to denote the small contribution that I myself bring to this research. As a novice feminist researcher my opinions strengthened throughout this research journey, however, a more experienced feminist researcher may have viewed this research with a stronger sense of patriarchal domination than I have. Nevertheless, my views and data analysis have been strongly influenced by feminism, even though a very humble claim to feminism is made. According to Gore (1992) “the energies of those of us who advocate critical and feminist pedagogies might be better directed at seeking ways to exercise toward the fulfilment of our espoused aims, ways that include humility, scepticism and self-criticism” (p. 68). Given this, assumptions brought to this research are that women are oppressed, the person is political, and that consciousness raising processes are fundamental to an understanding and changing of reality (Speedy, 1991). The issue of consciousness raising is discussed in greater detail later in this chapter. Furthermore, as both critical theory (in the Frankfurt tradition), and the postmodern work of Foucault are both patriarchal dominated, to omit a feminist perspective would be to perpetuate this patriarchal hegemony.

The postmodern perspective primarily draws upon the work of Foucault, which I have utilised predominantly for its ability to describe power relations. The notion of power as described and exercised by Foucault situates power within society rather than above it (Silverman, 1985). I found this subtle yet compelling notion of power useful in analysing nursing relations within a complex organisation, and I believed it complemented the critical and feminist methodology. Foucault (1980a) advocated for an “ascending analysis of power,
starting … from its infinitesimal mechanisms … and [to] then see how these mechanisms … have been … utilised, involuted, transformed, displaced, extended etc, by ever more general mechanisms and by forms of global domination” (p. 99). He further stated that “only if we grasp these techniques of power … can we understand how these mechanisms come to be effectively incorporated into the social whole” (p. 101). The work of Foucault, whilst predominantly utilising postmodern concepts, transverses modern and postmodern notions, particularly in his later work with his conceptualisation of the subject and notions of agency (Best & Kellner, 1991). The major use of the work of Foucault within this study is in the analysis of the data and is further explicated in the section titled Postmodernism and Foucault.

Whilst several notions have been adopted from the postmodern perspective, a complete or extreme postmodern view was not selected due to the desire to make space for individual nurses to speak. Therefore, maintaining their centrality as subjects was essential. From a feminist perspective it was important my study was rooted in human experience (Flax, 1999). My underlying tensions with postmodern notions of subjectivity and agency also influenced my position as with perhaps foremost my concern to explicate the reality of subordination and desire to improve the lives of nurses if possible. However, questioning modernist essentialist assumptions, seeking and acknowledging multiple truths, and interrogating discourse were postmodern notions that I found both useful and compelling, such that marginalised discourses and possibilities for alternate conceptions and subjectivities have been embedded in the data analysis and discussion.

Given these broad areas of theoretical influence, I will explicate further the essential components from each that I have drawn. In many instances the positions fit well, for example, the agenda of social transformation for both critical social science and feminism. In other areas I will attempt to define my particular use of the notions. Critical theory and postmodernism need to be confronted and articulated in their disparities so that their very tensions and differences provoke new thinking and new political practice (Best & Kellner, 1991). Positioning myself as having a nonunitary subjectivity facilitates movement between the paradigms, problematises the notion of distinct and fixed borders, and draws attention to the issues of representation and truth.

Researcher beliefs, assumptions, ontological, and epistemological position—

Echoes of self
Fundamental to my search for a theoretical foundation I became enmeshed in philosophical questions central to my broad mode of enquiry. Major questions pertained to the nature of human beings, nature of knowledge and often in relation to the former issues, a diagnosis of
what is wrong with society and how it could be corrected. As assumptions undergrid our understanding of what we judge to be human nature and “inform our criteria for appropriate behaviour in the personal and political world” (Brookfield, 1990, p. 177), this study also represents my own journey of critical reflection and inquiry into human nature and its potential. Within my choice of theoretical paradigms there exists a variety of differing views on these issues. The area of overlap between the theoretical perspectives I utilise delineates the field and reflects my personal positions. My journey so far is reflective of the following positions.

Ontologically I believe in a socially constructed reality and a physical reality outside of human construction. That social reality is “founded upon thought objects constructed by the common-sense thinking of … [persons] living their daily life within the social world” (Bryman, 1992, p. 51). My interpretation of critical theory and the later work of Foucault are consistent with this premise. Further to this understanding, I also endorse the postmodern notion of multiple realities and recognise the unintended subordination that can occur within a critical perspective in utilising grand theories. Therefore, I support multiple realities rather than a unified truth. Unlike some postmodern thought that views reality as pure illusion and intertextual, and doubts the value of reason (Rosenau, 1992, p. 23), my understanding of reality and truth is both contextualist and teleological in that I affirm and am aspired to a positivist goal. I concur with Berger and Luckmann (1967) that power is a question of conflicting definitions of reality and where particular people have the power to construct and enforce their definition of reality it is due to socially prevalent economic and political definitions of what is possible, right, rational, and real.

Whilst Marx attributed the problems of the world to capitalism (alienation), and Christian thought attributes problems to a misuse of freedom from God (sin), most philosophical thought has noted an apparent problem with human nature and offers possible solutions to improve our social existence (Stevenson & Haberman, 1998). Feminist philosophy attributes the problems to patriarchy or the system whereby men have more power than women (Flax, 1999). Nietzschean notions such as the will to power, the Foucauldian conception of power and Deleuze and Guattari’s (1987) notion of desire conceptualise a more dynamic process of social existence that exists with modernity. Stripping modernistic beliefs of human progress from their writings many postmodern authors call for the end of the humanistic subject (Rosenau, 1992) and describe social interaction as a battlefield or contested terrain (Foucault, 1977). Ontologically and including my experience of living in this world, my views are consistent with this notion of social organisation as a complex contested terrain, which closely parallels at times the work of Machiavelli (1961). However, I maintain or do not wish to relinquish my faith in human beings as having the potential or agency for
fostering values and action that promote the reduction of social injustice and inequality. Given this somewhat cynical or pessimistic view of much human behaviour, I believe the requirement to strive for a better existence is even greater. Wright and Sayre-Adams (2000) described “light and love in ourselves, but also our shadow side” (p. 115). Activities of compassion, sharing, valuing others, supporting, and caring for others is also evident in social life, and to relinquish support for these positive values would be to extinguish faith in life itself. It is interesting to note that significant proponents of postmodernism such as Foucault (1988a) and Rose (1999) who advocate as antihumanists still articulate an ethical stance albeit without humanistic morality.

**Modernity, post-modernity, and the question of social progress—**

*And so it is Christmas (War is over)*

A central tenet of modernism as a philosophy of thinking is the logical positivist approach to knowledge development (Bryman 1992). Providence and progress are key concepts with history moving forward in a linear fashion toward a specific goal and the conviction that things are generally improving (Lyon, 1999). Modern science is based upon the positivist, empiricist, rational-logical model whereby observation and quantification are highly valued and emotion, feelings, and intuition regarded poorly. Modern science, however, has been questioned for its many inadequacies and assumptions (Rosenau, 1992), and has been described as “shallow, atomistic, observationalist and certain” (Harré, 1997, p. 9). Inadequacies of modern positivistic science include the failure to produce promised results, tragedy from short term errors, justification of normative positions, and legitimisation of the preferences of the powerful (Rosenau, 1992). Kuhn (1970) aptly described the discrepancy between how modern science purports to work in theory and how it actually functions. Modern science and modernity has also supported the masculine reason—feminine emotion dichotomy resulting in the social devaluing of women (Ferguson, 1999).

Modern science and modernity is also linked with the notions of progress and truth. As articulated by Best and Kellner (1991), “for some modernity is characterised by innovation, novelty, and dynamism” (p. 2) and reason is the source of progress in knowledge and society. A compelling criticism of modern science is its failure to solve major problems including hunger, poverty, environmental deterioration, and the threat of nuclear weapons. My convictions for a critical paradigm strengthen when I watch news reports and with horror see bomb blasted, debilitated, and blinded children; the result of violent wars. I am mindful of media manipulation and the flood of male opinion. I cringe when I hear the discourse of retaliation, of war, of carpet-bombing and revenge, and note with dismay the heightened opinion polls of Western leaders. I feel ashamed that the Western World is so proud of its affluence, so aggressive in its actions and so calculating with its leaders’ ability to influence
and gain positions of political advantage. I wonder if woman/mankind has progressed at all. My commitment to critical research that actively attempts to reduce inequality and improve lives is affirmed. I concur with Held (1993) who asserted “we need to examine the moral acceptability of using violence to enforce law and order, to effect political change (as in terrorism and revolution), or to achieve personal gain (as in the legalized brutality of some sports)” (p. 141). Whilst extreme postmodern notions are academically appealing, their apotheosis of fragments, dull nihilism, apathy, and inertia tendencies may be construed as a luxury (Best & Kellner, 1991; Rosenau, 1992). Therefore, whilst I situate my philosophical and methodological position as that of rejecting much of modernity and tending toward a postmodern view, I also hold hope and desire for social change and improved equality. Similarly, Walker (2001) noted

It is compelling to conceive of our times as ‘post,’ or after the modern as … such a philosophical position makes it imperative to advance a serious assessment of the ‘structures and forces’ of modernity—and there is much evidence to suggest they are in need of rigorous scrutiny. (p. 60)

It is at this point with my critique of modern science and positivism that I wish to elaborate in further detail on critical theory returning to postmodernism later in the chapter.

Critical theory and critical social science—*To dream the (im)possible dream*

A description given by Fay (1987) encapsulates my notion of critical theory and reticence to abandon this paradigm in favour of the purely apolitical postmodern. According to Fay “critical social science is a medium by which many people express their most profound longings” (p. 2). This unashamedly and somewhat utopian desire to create change and carry the vision of an improved existence is central to my notions of critical theory. Critical social science is an ideologically oriented inquiry. It includes many critical theories including Marxism and those from the Frankfurt school of thought, feminism, some forms of politicised Freudianism, participatory inquiry, and studies by authors such as D. Laing, Ernest Becker, and Dorothy Dinnerstien (Fay, 1987; Guba, 1990). Fay (1975) identified critical social science as being a study of the nature of social science, rather than just a study of modern society as typical of Horkheimer, Adorno, Marcuse, Habermas, and other researchers of the Institute of Social Research at the University of Frankfurt. In doing so, he insisted on its scientific character. My preference for the term *critical social science* is for its overarching and encompassing aspect rather than its affiliation with the discourse of scientific method.

The aim of critical social science, as described by Fay (1987), “is to redress a situation in which a group is suffering as a result of the way their lives are arranged and to overturn these
arrangements and to put into place another set in which people can relate and act in fuller more satisfying ways” (p. 29). Similarly, Comstock (1982) described the function of critical social science as “to increase the awareness of social actors of the contradictory conditions of action which are distorted or hidden by everyday understandings” (p. 371). With the stated assumption of nurses and women being oppressed groups, critical social science provides the major theoretical impetus for this study. Critical social science disputes the scientific enlightenment assumption that there is a foundation of knowledge existing outside of human consciousness and that knowledge can be divorced from human values and norms (Allen, Benner & Diekelmann, 1986; Kincheloe & McLaren, 2000; Morrow, 1994). Critical social science is critical of modernity in respect to social progress and technological rationality, however, Jurgen Habermas (1984) contended that emancipatory potential was still possible with modernity through his Theory of Communicative Action. Critical social science, whilst refuting many aspects of modernism and scientism, still upholds many modernistic assumptions.

Current critical social science acknowledges that domination occurs in many forms and not just by economic determinism. Feminisms display that patriarchy preceded and was an essential adjunct to the growth of modern capitalism. Kincheloe and McLaren (2000), however, argued whilst it is important to critique the multiple axes of domination, including race, gender, and sexual orientation, economic factors cannot be separated from the other axes. Furthermore they should not be omitted, particularly with current globalisation and the merging of cultural pedagogy with the productive processes of advanced capitalism. Class struggle has become an outdated issue to gender and ethnicity in recent postmodern ethnography (Kincheloe & McLaren, 2000).

Critical social science has been utilised to a limited extent within organisational and management studies, primarily following the work of Horkheimer and the tradition of the Frankfurt school with critical theory. Whilst most management literature portrays management as a socially valuable, neutral, technical function critical studies question this as being unproblematic and are concerned with the lives of employees, managers, consumers, and citizens. Viewing management from a social-political perspective rather than a technical function allows for the “careful scrutiny of managerial discourse and practice in terms of voices that not only speak loudly, but also quietly or cannot–yet–be heard. Only very recently have feminist voices been heard in management theory” (Alvesson & Willmott, 1992, p. 6). Whilst the number of published studies are limited, critical social science has been utilised within organisational and management research to study disciplinary power (Deetz, 1992a), the organisation of pleasure (Burrell, 1992), sexuality in organisations (Hearn & Parkin, 1987), managers (Nord & Jermier, 1992), marketing discourse (Morgan,
social work in health care (Jones & May, 1997), and the control of nurse expertise within health organisations (Chau, 1989). Nord and Jermier (1992) described the multiple implications for managers in engaging with critical management studies, including the notion that managers themselves are frequently subordinate and oppressed by other groups and that intra group subordination also occurs. Critical theory questions taken-for-granted assumptions about contemporary social reality and of the purpose of contemporary forms of management theory and practice (Alvesson & Willmott, 1992). As the topic of this study concerns nursing management and the nurses within the study were employed within a large health care organisation, critical perspectives of organisations and management also inform the study.

Critical social science has been increasingly advocated and utilised in nursing scholarship (Drevdahl, 1995; Fulton, 1997; Glass, 1998; Hedin, 1986; Henderson, D., 1995; Kim, 1999; Manias, 1998; Stevens, 1989; Street, 1992; Thompson, 1987; Varcoe, 1996). Thompson asserted “critical scholarship in nursing can speak about the process of reweaving, regaining confidence in new definitions of reality, regaining a commitment to new definitions of nursing practice and feeling grounded in new value orientations” (1987, p. 37). Critical nursing inquiry has shattered some of the silence in nursing about social ills like racism, classism, and heterosexism and may be combined with language studies to explore the interconnections among language, discourse, power, and society (Boutain, 1999b). Nurses’ practical experience of nursing and the contradictions they are exposed to result in nurses frequently adopting a critical approach as they have an interest in and of, life as a woman (Thompson, 1987).

The critical theory of Habermas entails individuals being engaged in argumentation directed toward rational will formation for the praxis of critical theory and to authentically engage social action and social actors (Carr & Kemmis, 1986). Habermas (1970) stated “in so far as we master the means for the construction of the ideal speech situation, we can conceive the ideas of truth, freedom and justice” (p. 372). This is, however, one of my concerns with critical theory. I concur with Bernstein’s (1979) criticism of the work of Habermas that the notional “ideal speech situation where a democratic form of public discussion … that is free of any threat of domination, manipulation or control” (Carr & Kemmis, 1986, p. 142), does not exist. Whelehan (1995) also aptly noted the problems of consciousness raising in some feminist groups. She asserted that “a democratic structureless group does not of course guarantee equitable discussion, and can just as easily allow the most vocal members to take over and create an unacknowledged internal hierarchy, where power relationships hold sway more tenaciously for being denied” (p. 72). It is at this point that I wish to consider the
interwoven issues of marginalisation, oppression, and domination as aspects of critical social science in greater detail.

**Marginalisation, oppression, and domination—*The sounds of silence***

Critical theory attempts to give voice and improve the lives of a marginalised group. The marginalised are a minority existing at the periphery of a dominant majority (Hall, 1999). A similar but slight variation to this definition is that marginalised groups or individuals live between two cultures or levels in a hierarchy, having left one culture but without full acceptance into the other culture (Andersson, 1995). Marginalisation and oppression are often used interchangeably, as the end result of stress, feelings of helplessness and conflict is common to both. Group oppression has been described by Young (1990) as

when the benefits of their work or energy go to others without those others reciprocally benefiting them (exploitation) …; they live and work under the authority of others, and have little work autonomy and authority over others themselves (powerlessness); … they are stereotyped at the same time that their experience and situation is invisible … they have little opportunity and little audience for the expression of their experience and perspective … (cultural imperialism); … [and] group members suffer random violence and harassment motivated by group hatred or fear. (p. 128)

Nursing, because of its lack of power and control, are an oppressed group, as the values of medicine and the medical model have been internalised by nurses and the identity of nursing has been subsumed by medicine (Roberts, 1983, 2000). The oppression of nurses is well documented in the literature and includes notions of horizontal violence, self-hatred, low self-esteem, and lack of confidence (Attridge, 1996; Attridge & Callaghan, 1989; Duffy, 1995; Farmer, 1993; Lee & Saeed, 2001; Roberts, 2000; Skillings, 1992). Delacour (1991) described nursing as having been “constructed by powerful discourses including those of medicine and gender, in which our society’s dominant ideologies are enshrined” (p. 413). The abuse (Gasparis & Swirsky, 1990), and oppression and exploitation of nurses has been further substantiated (Ashley, 1980; Hedin, 1987; Mason, Backer & Georges, 1991; Thomas & Droppleman, 1997). Nurse managers, leaders, and executives are also oppressed and suffer marginalisation, as well as isolation (Roberts, 1997; Silvetti, 1990). The oppression of nurses must be taken as a given in order to move on to what actions can be taken to improve these situations (Hedin, 1987). Marginalisation and oppression are intertwined and it is the sociopolitical process that produces in groups both vulnerabilities and strengths or resilience (Hall, 1999). For many individuals there is a *double whammy* as described by Glass (1998), that is, the double oppression of being a female in a male dominated world, as well as being a nurse in a subordinated health occupation.
Given the oppression and marginalisation of nurses, critical social science provides an appropriate theoretical basis for this study. Whilst the concept of marginalisation is usually associated with negative traits, it can be reframed to view possibilities for new cross cultural exchange and for those marginalised to examine existing norms and values which are taken for granted by the mainstream culture (Andersson, 1995). Critical theories support the notion of marginalisation but also indicate that collective social activism is necessary for social transformation (Hall, 1999). Without negating collective action, I believe the extent of oppression of nurses required that the ontological processes used in this research were sensitive to the vulnerabilities of each individual. Overt horizontal violence (Duffy, 1995), and the sensitive and personal nature of the issues, led me to research, talk, and conduct in-depth interviews with individuals rather than as a collective group. This allowed for the reality of the context to be embedded into the research, that being the vulnerability of the individuals and acknowledgement of the highly complex and socially constructed environment. As asserted by Kelly (1996), “nurses are socialised to obedience and speaking up is particularly difficult for hospital nurses … who may be punished for being outspoken by their own—other nurses” (p. 31). Penelope (1990) furthered this notion in asserting women are judged against the expectation of silence rather than men who in fact talk more than women, so that the myth of women’s talkativeness reinforces that “the best woman is a silent woman” (p. xxv). The difficulty for nurses to talk about their work (Lawler, 1991a), and the lack of voice for nurses, has been well noted (Buress & Gordon, 2000; Thomas & Droppleman, 1997). I believed the intent of making space from which nurses could speak and acknowledgment of individual truths would be more apparent if individual sensitivity and safety was optimised and individuals felt acknowledged, validated, and safe to verbalise their vulnerability as well as strengths.

This view is consistent with the process outlined by Roberts (2000) for liberating the oppression of nurses that includes understanding and talking about the dynamics that perpetuate the system, developing awareness, professional and personal pride, connecting with other nurses, internalising the new positive image, and finally, political action. The end process of political action within critical theory is unlikely to succeed without adequately acknowledging the context (Gore, 1992), and without adequate time and process to gain voice (Glass, 1998). Dilemmas of power exist in interviewing vulnerable individuals within focus groups (Owen, 2001), and acknowledging and embracing vulnerability provides for a more authentic relationship (Malone, 2000). The importance of trust, support, and safety is essential for de-silencing and reclaiming voice among nurses (Glass, 1998).

Davis and Glass (1999) advocated integrating critical theory with postmodern notions that give centrality to the individual, uncover individual uniqueness and celebrate differences to
potentially avoid monolithic theories that by their very inclusiveness can be disempowering to the already marginalised individual. This was also articulated by hooks (1984) when she vividly identified the further oppressive problem of critical theory and the potential negation of multiple oppressions of race and class when essentialist theorising focused on gender alone. Postmodern notions of multiple oppression and multiple truths are linked with critical theory and discussed in further detail below in the section titled Postmodernism and poststructuralism.

**False consciousness, education, and reflexivity—Echoes and encores**

Critical social science is frequently associated with notions of self-estrangement theory and benevolent education to enlighten and liberate members from their false consciousness. This view highlights the risks of critical research being condescending, simplistic and paternalistic, locating the researcher as the supreme liberator and members as perhaps not as intelligent or enlightened as the researcher/liberator. Gore (1992) noted the unreflective *us* and *them* position that this can create. I prefer the notion of Fay (1987) that for “a practical force critical theory must become an enabling, motivating resource for its audience” (p. 29). I interpret audience to be both the participants of the study and readers of publications from this research. With this perspective of critical theory in mind, I aimed to seek and make space for the voices of nurses, encourage and support their voices, their issues and ideas, including what was often not publicly voiced, with the promise to publish their voice and issues as faithfully as I could. Naming experiences gives voice to our world and affirms us as active social agents with a free will and purpose (McLaren & Giroux, 1997).

Reflection is a dialectic process, which looks both inward at the historically and socially embedded person and outward through an action-orientation to the existing situation (Kemmis, 1985). Reflection affords us not only with the opportunity of extraordinarily re-experiencing the ordinary, but also provides a vehicle through which we can find ways to change and improve the ordinary (Cash, Brooker, Penney, Reinbold & Strangio, 1997; Quallington, 2000). Critical reflection, according to Street (1991), is a goal-directed journey of self-discovery that enables us to challenge situations with our own findings. The work of Street (1991) draws upon premises of Schon (1984) that professionals in their everyday practice face unique and complex situations, which are unsolvable by technical rational approaches alone.

Habermas (1971) described *knowledge-constitutive* interests to include three categories, with the former being interests of technical control which has engendered a technical domination and distortion over the later two, being practical and emancipatory interests. To correct this unbalanced distortion, we must act and think self-consciously, reason and make decisions on
the facts known about a situation, and the socially accepted rules, to lead to true emancipation (Gillespie, 2000). Applying the notion of reflection to nursing practice Johns (1996) and Cash et al. (1997) described reflection-on-experience as a process that provides the practitioner with a window for them to look inside themselves and their practice with a critical eye as they strive toward understanding multiple images and realising the meaning of desirable relationships, situations, and work in their everyday practice. Johns cautioned if the process involved a supervisor in guiding the reflection it could become a technology to produce an ideal worker. Critical self-reflection may be exciting and liberating but also can be highly disturbing by adding to oppression the realisation of oppression as tensions and contradictions disturb fundamental ways of understanding self and the world (Cox, Hickson & Taylor 1991). On a more optimistic note, Cox et al. (1991) noted that in our reflection we can hope for the surfacing and new expression of some possibilities that begin an ongoing search for freedom and justice.

In respect to research, Calás and Smircich (1991) noted reflexivity is the process of paying attention to the relationship between knowledge and the ways of producing knowledge. Reflexivity draws attention to the complex relationship between the process of knowledge production and the various contexts of such processes as well as the involvement of the knowledge producer (Alvesson & Sköldberg, 2000). As a woman and nurse I identified myself as a co-participant in the research. I held high admiration for the clinical skills, managerial skills, and nursing knowledge of each participant, which I acknowledged to participants. I often questioned my own ability and skill in listening to these individuals and aimed to ensure I maintained a high level of reflexivity throughout the research process, including the documentation of thoughts in my reflective field notes. I also shared with nurses some challenges to dominant ideas regarding nursing management that I had gleaned from my critical reading of the literature, my critical and postmodern perspectives, and clinical observations.

My interpretation of consciousness raising is not of a more intelligent being bestowing or imparting ideas to participants, but to create the opportunity for, give permission to, and validate nurses finding their own voice. The idea of making space for others to speak (Ellsworth, 1992; Varcoe, 1997) represents this concept of voice as with participants rather than for participants. As a co-participant and researcher, my voice is also represented as well as representing the author’s voice as final author. The notion of giving voice and representation of voice within critical theory follows the modernistic assumption that voices can be accurately understood, reflected, and represented in text. Despite my desire to make space for others to speak or to give voice to nurses, the research design, questions asked, and final written text is my voice, even with the strategy of multiple subject positions. This issue
of authorship and representation is further discussed below whereby postmodern notions intersect with critical theory.

**Struggling with enlightenment, empowerment, and emancipation—**

*You’re the voice … we’re not going to sit in silence*

Empowerment according to Chinn (2000) is “the process by which people (including nurses) become able to act from a source of inner strength, [are] able to sustain against odds large and small, and [are] capable of taking matters into their own hands” (p. v). Empowerment, however, is very often defined by its absence (Fulton, 1997; Schmieding, 1993). Defining attributes of *empowerment* in the literature are mutual participation, active listening, and individualised knowledge acquisition (Ellis-Stoll & Popkess Vawter, 1998). Enabling, enlightening, empowering, and emancipating are all central tenets of critical social science yet their usage if often problematic and contested. Enlightenment, according to Grundy (1987), is the process whereby there is comprehension of explanations of experience which are other to the *natural* explanations which have always been accepted. Emancipation does not always follow enlightenment but lies in the possibility of taking action autonomously. Action may be informed by reflective insights but not prescribed by them as praxis involves reflection on action (Grundy, 1987).

Kuokkanen and Leino-Kilpi (2001) identified empowerment as a process steered by personal values and endeavours as well as by environmental factors and cautioned of the recent proliferation and popularity of organisational studies advocating empowerment as a management tool. Within these studies, empowerment is defined as the ability to get things done and measured by increased productivity and organisational effectiveness (Laschinger, 1996). Within the discourses of management the meaning of empowerment may differ from that of social movements attempting to raise issues of inequality (Clarke & Newman, 1997; Collins, D., 2000). Management practices that espouse empowerment should be critically analysed before being introduced (Hewison & Stanton, 2003). Within nursing, empowerment is also often linked to advocacy and enabling in the relationship between nurses and patients (Ellis-Stoll & Popkess-Vawter, 1998; Kuokkanen & Leino-Kilpi, 2000). Difficulties with paternalistic and authoritarian issues such as the emancipatory authority of the teacher in classroom teaching is described by Ellsworth (1992). Similarly, Skelton (1994) within nursing linked empowerment with the notion of *I know best* in changing behaviour via a method indicating it was the individual’s idea in the first place. He further contended that “empowerment can easily be accommodated to existing power structures … [and] remain rhetoric on the lips of well entrenched professionals, who are not themselves likely to demystify their own knowledge or to concede control” (p. 417).
Clare (1993) noted that the education and socialisation of nurses that occurs in hegemonic university and health care institutions serves to ensure nurses learn to think and act in ways which are defined for them by dominant groups and which they then accept as natural, common sense views of social reality. She advocated this cultural reproduction and the rhetoric of emancipation be reduced by critique of teaching practices and processes rather than just curriculum content. Greater acceptance of experiential knowledge, reflection, and open dialogue between teacher and student may, according to Clare, allow nurses collectively to “discover processes and act to transform the social structures” (p. 1037). The notion of empowerment that I utilise within this research is that of Chinn (2000) whereby nurses “become able to act from a source of inner strength” (p. v), which I hope results from their ability to find and give voice to their own experiences and desires. This is similar to Chandler’s (1992) definition that it is “to enable to act” (p. 65).

In an analysis of the literature, the term empowerment has almost exclusively implied it to be a process emanating from individuals, denoting power and control (Ellis-Stoll & Popkess Vawter, 1998). Power is bestowed or given by an individual. There is a lack of clarity regarding human tendencies of relapse, fallibility, and failure to change, as well as a lack of information regarding the relationship of empowerment with motivation (Ellis-Stoll & Popkess Vawter, 1998).

In terms of this study, I respected that nurses were free agents to participate, consider change, or to reject any part of the process. Furthermore, I respected the opinion of each individual on their life journey. I was somewhat reassured as a co-participant that I was not the keeper of all answers. On many occasions I reflected ‘What if I had it all wrong’? As Ellis-Stoll and Popkess-Vawter (1998) stated, an area requiring investigation concerns the skills and knowledge of nurses to initiate the empowerment process. I often questioned my ability to participate in this process with other nurses, given that my clinical nursing background was critical care and I felt I held the label of being technocratic rather than a communicator. I recognised and reflected frequently on my own personal limitations of fluctuating confidence as a nurse and woman as I progressed throughout the study.

I also reflected that my concept of power was not one whereby power was reified as an object that could be given or bestowed. Gore (1992) also expressed concern with the notion of en-power as that whereby power can be given, provided, controlled, held, and conferred as property. This potential limitation of critical social science is addressed by my use of the notion of power from Foucault’s work, which differs from that of power as property and instead links power inextricably with knowledge. Furthermore, I concur with Chinn’s (2000) and Chandler’s (1992) notion of empower who defined empower as “to enable to act … [and therefore] quite different from the definition of power” (p. 65).
The construction of empowerment in critical theory also has been challenged by Gore (1992) in respect to the accorded extraordinary abilities or the overly optimistic views of the agent of empowerment, which can risk ignoring the particularly difficult context. I concur with this view as my largest concern with critical social science. It potentially accords the ability to empower in a highly complex and socially constructed environment as overly simplistic. For this reason and others, my initial intent was to create a context and space for nurses to be able to individually reflect and speak, and I held hope that through this, further benefit would accrue.

The process of gaining voice is not linear with a distinct point of arrival, but individuals move dialectically between positions and at times return to turmoil as well as at other times solidify and speak out (Glass, 1998). Rather than view empowerment as a place or discrete goal to be achieved empowerment, according to Glass (1994), can be viewed as a process of empowered states that also are neither necessarily linear nor static. Kincheloe and McLaren (2000) stated “no one is ever completely emancipated from the sociopolitical context that has produced him or her” (p. 282). Given this notion, I question how empowerment or change may be measured or knowledge of change sought, that change may not be observed, or it may be minimal. Critical theory must not promote fantasies of total redemption as human beings are enmeshed in a reality of enduring cultural traditions and often-unyielding personal identities that no critical theorist can ever wholly unravel (Luke, 1991). As a woman and nurse I also grappled with daily life and found I frequently felt overwhelmed with the struggle against domination and repeatedly could see few vehicles of escape or answers to alleviate the complexity of social life. I was a product of society and bound and shaped by my own subjectivity and internal discourses. The process, however, of freely speaking, of being heard and supported, and viewing life from alternate perspectives I felt assisted me. Therefore, the making of space for nurses to speak from is an important aim of this research with the intent to improve the social lives of nurses. This is consistent with notions of critical social science.

**Attempting diversity and multiplicity—Simultaneous symphonies**

Alongside the issues of enlightenment and emancipation, the risk of unintended domination and further subordination is a noteworthy issue in critical social science. The domination and subordination of women inherent in *The Theory of Communicative Action* by Jurgen Habermas utilising the normatively achieved action context and the model of private/public relations, has been detailed by Fraser (1989). A framework of critical theory that foregrounds all subordination and domination not just exclusively the evil of welfare state capitalism has been advocated by Fraser.
In a similar criticism of critical theory, Ellsworth (1992) advocated critical theory held some repressive myths perpetuating relations of domination. Fuller (2000) and Boutain (1999a) also contended that social identity is not static and multiplicity and multicultural contexts should be further highlighted in critical research. Fuller stated critical theory “reaffirms the primacy and transcendence of a scientific clarity that knows what is best for its subjects. Thus it … effects a reaffirmation of the culturally reductive and totalising practices that it seeks to contest” (p. 97). For these reasons critical social science has been blended with notions of postmodernity that highlight individual, local, and pluralistic views, rather than a totalising grand narrative that risks further subordination. These postmodern notions are discussed later in this chapter, following a discussion of feminisms.

Given the above concerns and requirement to accommodate other theoretical positions, I reflect on why I have held onto critical social science as the major theoretical impetus. I return to my intent and hope that, through this research, there is a possibility for individuals to gain voice, create change if they wish, and perhaps improve their lives. Freire (1973) spoke of oppression as the culture of silence and, similarly to Habermas (1984), defined emancipation as the finding of one’s own voice. Emancipatory inquiries view knowledge production as a liberatory act (Henderson, D., 1995). This may be through their own individual involvement with the research, including reflection upon the topic, through the ability to articulate and safely speak to someone genuinely interested and empathetic to their experiences including what may otherwise be unsanctioned, and/or from publication and dissemination of the research findings. There is congruence between this notion of knowledge production and Foucault’s (1980a) postmodern position linking knowledge with power in a positive productive sense. As critical theory in the Frankfurt school tradition is bereft of any gender critique and perpetuates hegemonic discourses, feminism itself is discussed separately so as to gain some prominence. Important feminist influences are now discussed.

**Feminism—Let’s hear it for the girls**

Feminist theories share with critical theory many notions (Agger, 1991; Bent, 1993; Morrow, 1994; Webb, 1993) such that feminist theory can be categorised as a theory of critical social science (Fay, 1987; Guba, 1990; Lather, 1991). Held (1993) succinctly stated “a primary aim of feminism is to end the oppression of women” (p. 90). Lather (1991) further elaborated that the goal of feminist research is to correct the invisibility and distortion of female experience in ways to end women’s unequal social position. In this respect, critical theory and feminism parallel each other in their desire to improve social existence by revealing socially constructed distortions and empowering or enabling a positive change. However, feminist
theory differs from the critical theory of Habermas (1989) who identified only problems of system and life worlds and androcentrically interpreted reproduction (Fraser, 1989). Feminism centralises the social construction of gender and also, according to Bent (1993), “by being politically committed, feminists bring the personal to the political arena, for public life is an extension of everyday life, and everyday circumstances are fundamental to how and where one exists in the world” (p. 298).

Feminist research shares with critical theory ontological and epistemological links such that methods of doing research reflect inherent theoretical and epistemological constructs (Walter, Glass & Davis, 2001). Reflection and reflexivity, as described previously, is a construct that equally applies to feminist thought as to critical theory. Both acknowledge overt political intent in their methods and that value free knowledge is not possible, truth is contextual and historically explicit. Feminist thought and action is inherently political, challenging prevailing attitudes of devaluing and discounting women (Carreyer, 1995; Chinn, 2001). Feminisms share with critical theory the notion of praxis, however, again the focus differs between the social process of labour (critical theory in the Frankfurt tradition) and that of gender (feminism). Praxis entails a reflexive relationship between theory and practice in which each builds upon each other (Grundy, 1987). Feminist ideas that are central to feminist praxis are an implicit set of beliefs underlying the explicit ethical-political statements where feminist groups collaboratively deal with the effects of women’s oppression (Chinn, 1989). Feminist praxis endorses the integral relationship between understanding women, women’s experiences, their socially constructed position, and feminist theories. Flax (1999) noted feminist theory is the foundation of action where there is a commitment to change oppressive structures and to connect abstract ideas with concrete problems for political action.

There is not one feminism, but rather many feminisms (Glass, 2000; Lather, 1991; Speedy, 2000; Whelehan, 1995), the definition itself being contentious and currently reflecting an attempt to accommodate difference and diversity rather than exclusion (Caine, 1995). Three major premises are central to almost all feminist thought. These include (a) women are oppressed within patriarchal societies, (b) the person is political; that is, there is a direct relationship between social change and political action, and (c) consciousness raising processes are fundamental to an understanding of women’s reality (Glass, 2000; Speedy, 1991; Webb, 1993). The premise of consciousness raising is debated by some feminists (Glass, 2000).

The feminist tradition of intellectual thought may be traced to identify different types or waves of feminism. The historical development is remarkable, given that “as women, feminists lacked the financial and institutional resources to establish schools of thought or
formal ways of transmitting their ideas” (Caine, 1995, p. 3). Despite this historical
disadvantage that itsl-epitomises women’s oppression, three distinct but interconnected
waves are discernable. Each has been supported by differing theoretical stances and may be
identified by their historical development in time and differing issues. Glass (2000)
described the first wave as occurring at the turn of the century and being primarily concerned
with women’s rights and equality. The second wave, commencing at the end of the late
1960s, again concerned women’s rights but also included notions of freedom, liberation,
enlightenment, sexual revolution, and specific women’s issues such as abortion, sexuality,
domestic violence, incest, and rape. Second wave feminism demonstrated the person is
political by public action in demonstrations, attempts to influence governmental and non-
governmental bodies, and by consciousness raising groups. Major grouping evolved that
included Marxist (anticapitalist), liberal (equality), radical (interventionist), and lesbian
(sexual orientation) feminists who each viewed their oppression and means for
transformation from a slightly different perspective. The third wave, commencing from the
1980s onwards, built upon or added new insight to the existing perspectives by
encompassing poststructural and postmodern theory to critique universalising, totalising
grand narratives, to focus on individual women’s experiences (Glass, 2000), and to call for
specificity of accounts in their historical context.

Feminisms developed with episodes of marked conflict, ruptures such as between radical and
liberal feminists (Whelehan, 1995), and differences and discontinuity (Glass, 2000; Jaquette,
1992; Pearsall, 1999; Scott, 2001). Diversity of feminist thought and methods for conducting
research is a prevailing strength as it provides for plurality of thinking, is inclusive rather
than exclusive of various women’s experiences, and can simultaneously celebrate difference
and diversity (Caine, 1995; Glass, 2000). Currently debated is the contemporary feminist
engagement with postmodern and poststructural perspectives. Concerns are raised that
preoccupation with discourse alone can obscure the lived realities of subordinate groups with
neglect of the social context and de-emphasis of economic and material relations of power
(Humphries, 1998). Fragmentation can arise from widening divisions among women
(Jaquette, 1992). Postmodern perspectives may erode the moral grounding, undermine
possibilities of utopia, emancipation and social transformation (Reed, 1995), contest
fundamental definitions threatening the feminist agenda, and assume a more sophisticated
position alongside antihumanist men (Benhabib, 1995; Farganis, 1994; Whelehan, 1995).
However, given these concerns, feminist perspectives that do not adopt postmodern views
may also be questioned, as previously discussed regarding issues of authority, essentialising
categories, and enlightenment. Combining or integrating feminist and postmodern thought
can lead to a more integrated approach or middle ground (Agger, 1991; Glass & Davis,
1998; Humphries, 1998; Lather, 1991; McCormick & Roussy, 1997) with each perspective complementing each other and being mutually corrective (Heckman, 1990; Miller, S., 1997).

Feminist notions utilised within this study aimed to validate oppressive and experiential differences among women rather than adopt a monolithic unified view essentialising the category of women and regarding their experience as same. Feminist thought primarily utilised to inform this study is postmodern. The role of feminism is to challenge the hegemonic universals of the Western tradition, “to give space to feminist subjects and recognition to feminist voices … to insure that difference does not lead to inequality nor postmodernism to apathy” (Jaquette, 1992, pp. 149-150).

**Feminist knowledge, experience, values, and relationships—I am woman**

As a woman and co-participant, my experience of being in the world as a woman is both reflected in this study and has on many occasions been strengthened by utilising this mode of enquiry. On occasions when I became overwhelmed with the enormity of the study and the barriers to its completion, I reflected upon my situation and strengthened my resolve as a woman to overcome the barriers to further my study. I often thought that had I not been utilising a feminist framework I might have conceded defeat. The emotional components of maintaining self-confidence and overcoming fears were my largest difficulty. Having not undertaken prior feminist research, I am still unsure the extent to which this study influenced the development of significant female friendships, which were essential to the study. Insight into the value of relationships was gained and reading of literature broadened my attitudes, knowledge, and perspectives. My mother gently educated my early foundations for expecting equality, which she consistently followed up with such wonders as manuscript transcription (practical), critical insight into theoretical discussions (intellectual critique), and an enduring ear interfused with massive empathy (compassion and love). As daughters we are nurtured and trained by women, that we receive maternal love with special attention to its implications for our bodies, our passions, and our ambitions (Ruddick, 1999). It was often this relationship, together with that of my supervisor, that was the wind beneath my wings. I analyse these relationships to the experience of wearing a warm coat, that is, being wrapped in warmth, trust, acceptance, understanding and even if momentary, protection from the outside world. The principles are documented in theory (Glass, 2000) which mirrored my experience and the interconnectedness of feminist theory and praxis.

Feminist morality has furthered traditional moral theory orientated around justice, autonomy, liberty, and equality to explore caring relationships between actual human persons as a moral responsible behaviour, that may also be called an ethic of care or morality of love (Held, 1993). Women have a distinctive construction of their moral domain that centralises the
concepts of responsibility and care, and when the feminine voice is heard it appears moral
development proceeds from an initial concern with survival to a focus on goodness and
finally to a principled understanding of non-violence (Gilligan, 1999).

The human response of mutuality, or connectedness, is important in significant relationships
between women and can transform feelings of disconnection and repression into feelings of
connection and empowerment (Glass & Walter, 1998; Jerzac, 2001). Feminist research is
concerned with values and feelings and should be grounded in actual experiences closely
related to social change (Webb, 1993). Utilising feminist values of equality, recognition of
other and connectedness, as compared to bureaucratic patterns of hierarchy, internal
coercion, and external manipulation, Ferguson (1984) developed a nonbureaucratic vision of
collective life embedded in women’s experience. Feminist values can be highlighted and
utilised to reconstruct social situations and create spaces of importance for women. The
dualist dichotomy that assumes there is an essential difference between men’s and women’s
natures exemplifies women as being emotional and without or of limited reason in the
dualisms of reason versus emotion, spirit versus body, culture versus nature, and activity
versus passivity (Ferguson, 1999). These dualisms perpetuate and typify the subordinate
other as female that is lacking in male instrumental reason and intellect. Women are not
supposed to be able to do theory or to think abstractly, “so when you say to a woman, ‘ok,
now let’s do theory’, she’s likely to panic” (Flax, 1999, p. 10). I trust this study disputes this
fallacy.

The relationship of researcher to research participant in feminist literature should attempt to
address power imbalances and make relationships within the research more equal, non-
archical and promote interaction rather than one-way communication (Klein, 1983;
Webb, 1993). Whilst strong attempts were made within this research, it would be naïve to
suggest that a power imbalance did still not exist. Accomplishing power equality I found
particularly difficult. The topic and research questions were selected by myself, although the
impetus originated from a request that nurses wished to participate in a study I had just
completed. The site for the study was therefore selected, however, I am unsure if the
requester became a participant. The research was performed with the explicit understanding
that I, but not the participants, would potentially gain an academic qualification. Ribbens
(1989) identified some dilemmas and difficulties of power inequality in research, including
the issue of limited participant awareness of social structures and participant disagreement
with a feminist interpretation when the interpretation may be valid in its own terms.
Furthermore, data analysis may involve participants but, due to confidentiality, they are often
not privy to all the data or to final decisions on what is and what is not included (Lather,
1986a; Ribbens, 1989). Issues of interpretation and representation also impact upon power
imbalances in research relationships and are further discussed later in this chapter in the section titled *Postmodern knowledge, truth and representation*. It is important to acknowledge power where it exists (Wise 1987), and to attempt to face up to some of the paradoxes as honestly and as explicitly as we can, rather than trying to deny the power we do have as researchers (Ribbens, 1989).

Feminist views of knowledge are again aligned with critical social science in that they are post-positivist and opposed to the polarisation between objectivism and subjectivism evident in positivistic sciences. In a dialectical manner objectivity and subjectivity, agency and structure are intertwined and mutually implicate one another (Morrow, 1994). Feminist thought takes a positive view on subjectivity. Rather than presuming a gulf or space between the subject and object of knowledge (an effect of male interests), feminist theory accepts their interrelatedness. Grosz (1988) stated “the standard form of knowing subject [as constituted in male discourse] is considered disembodied, non-historical, non-sexual and non-social, a subject divided from itself in forms of self-knowledge” (p. 101). Feminist theory readily accepts the complicity of subject and object in knowledge-production.

Feminists believe in the inseparability of reason and emotion and problematise what is meant by knowledge, reason, objectivity, and validity (Ramazanoglu, 1992). Knowledge is not the learned reflection of the world, but rather shapes the world in particular ways, for particular interests (Waldby, 1995). Feminist theory ruptures and displaces sociably dominant knowledges in the interests and perspectives of women. Grosz (1988) identified the misogyny of prevailing intellectual knowledges as those that occur in sexist, patriarchal, and phallocentric knowledges. Liberal and conservative feminisms further develops existing theories to eliminate discrimination, however, they leave patriarchal and phallocentric knowledges intact compared to feminisms of autonomy which interrogate phallocentric knowledges (where woman are construed on the model of the masculine) to develop new forms of theory based upon women’s experiences and perceptions, rather than men’s (Grosz, 1988).

Fine (1992) invited research to de-silence women and for a moratorium on secret keeping.

To unearth the secrets is also to tap the costs of the silencing. Given that women are the repositories of social secrets and made to feel responsible for social problems, the hegemonic systems works perfectly. Women traditionally have not needed to be coerced into secrecy. To speak has been to betray self. So many have preserved systems that betray, as they sustain them. If they told, secrets of privilege, sexuality, danger, terror, violence, oppression, dependence, fears would be exposed/transformed.

(Fine, 1992, p. 21)
Feminism identifies how knowledge has been shaped to advantage men at the expense of the interests of women. Issues of knowledge, truth, subjectivity, and agency are important to feminist research, however, their interpretation and usage may differ within postmodern perspectives. My notion of feminist postmodernism and these issues are further described in the sections below titled *Postmodernism* and *Integrating and negotiating the borders of critical social science, feminism and postmodernism* after a discussion of other important aspects of feminist thought and the relationship between nursing and feminism.

**Men and feminist research—** *Performing gender*

Feminist research is not simply the study of women. It is not sufficient that feminist research is the study of women by women but the crucial difference is that it is carried out for women (Webb, 1993). Debate exists regarding the ability and/or acceptability of men performing feminist research. There is also some deliberation upon the question of their participation as the subjects of feminist research. Kremer (1990) advocated against the ability of men to perform feminist research, asserting that female spaces and meanings are elemental to feminism and that men who were truly empathetic to feminist thought would not try to colonise these meanings. The overwhelming majority of writers take the view that men cannot take part in feminist research as researchers (Webb, 1993).

The issue of whether men should be included as subjects of study is more contentious. Whilst many feminist authors advocate the exclusion of men as subjects of feminist research, Wise (1987) and Thorne and Varcoe (1998) have advocated, because women’s oppression is frequently by and in the context of men, men should be able to be included in research as subjects of study. Allen, Allman, and Powers (1991) have suggested, rather than perpetuate problematic social categories, it is better to deconstruct the gender dichotomy itself and to expand awareness of the forms of gendered existence. Similarly, Fine (1992) has argued against a gender difference frame as it creates an essentialist understanding of gender which renders invisible and unnatural a more full menu of human sexualities. Fine further argued “[We] must enter that space—to interrogate how women (and men) position and are positioned in ways that relay, inscribe, experience, and critique the social as a personal moment” (p. 25). Butler (1994) has also problematised the centralisation of gender into binary opposites (male and female) and advocated feminist studies should work against inadvertently maintaining the heterosexual and “institutional separatisms which work effectively to keep thought narrow, sectarian, and self-serving” (p. 20). Gender is dynamic and fluid, dependent upon the context, and can be viewed as being performed or something people do (Brown, 1988; Butler, 1990). This frees our notions of gender from the dualistic categories equated with biological sex, then assumed to equate with gender and therefore opens new avenues of thought about gender (Duerst-Lahti & Kelly, 1995). They further
asserted “gender, and not sex (women and men as categories), needs to be the focal point in
analyses of power relations” (p. 19).

The major principle of feminist study is not about who is included and who is not, rather it is
that women should derive some benefit (Bunting & Campbell, 1994). This study included
two men as participants as a stratified sample was sought that represented nurses at various
levels of the nursing hierarchy. This representation would have been difficult to achieve if
male nurses were excluded, considering senior nursing positions contain a heightened
Including their voices also perhaps more accurately represented the current discourses of
senior nurses, assuming representation can in fact be achieved. Both male nurses expressed
desire to participate in the study and their inclusion was thoughtful toward issues of
participant confidentiality. Androgenous pseudonyms have been allocated across genders so
as to deconstruct the gender dichotomy to prevent the essentialising of gender and to avert
reinscribing dualistic categories of gender onto participants. Reinscribing gender would have
explicitly worked against the intentions of the study as an unthoughtful act of
intertextualisation. The strategy of viewing gender as something people do (Butler, 1994)
rather than are sought to work against maintaining heterosexual separatisms. Complicit
gendered actions, I believed, were more prominent when they stood in question and were
detached from names implying gendered assumptions. However, so as not to lose specific
female voices, participants’ dualistic gender can be identified on closer reading by the use of
the binary he and she, and as is discussed in chapter seven, this was also a practical
consideration.

Wise (1987) advocated for males to be participants of feminist research but stressed the
importance of not merging male and female voices into one homogenous voice. Diversity
and individual perceptions were central to the methodology of this research. Having male
participants did, however, highlight methodological issues. Whilst attempting to be
supportive and receptive to ideas of participants, on several occasions I felt personally
insulted by comments from a male participant. Similarly, a couple of female participants
asserted statements that appeared blatantly gender blind and were derogatory of women. I
endeavoured to stand them aside and attempted to maintain non-judgmental relationships. I
was reminded of Millen’s (1997) issues of conducting feminist research with participants
who were not empathetic to feminism. Whilst I raised, explored, and shared issues of gender
with participants, I was simultaneously careful not to enforce my own personal notions upon
participants. The dilemma of balancing this act, or deciding the extent to which one should
pursue an issue, was difficult. Determining the truth, and the relationship of
researcher/participant to participant, was not straightforward. St Pierre (2000, p. 275) aptly
described the problems of truth and the disjunction that “gnaws at the research project” between the theory of the researcher and that of participants in ethnography. I agree that “within the interview situation the researcher as well as the researched is vulnerable” (Cotterill, 1992, p. 605). This personal tension I frequently reflected upon, including my own self as part of the research process, the decision to include male participation, and the dilemmas of personal subjectivity in clinical research.

**Nursing and feminisms—In discord and/or duet**

*Who nurses are and how they help to make things better is not even heard as a single tune played lightly on the woodwind above the crashing of the brass and percussion and the persistent grinding of the wind section.*

(Oakley, 1989 p. 324)

Cleland (1971) contended “our most fundamental problem in nursing is that we are members of a woman’s occupation in a male dominated culture” (p. 1542). Furthermore, according to Cleland, dominance is most complete when it is not even recognised. Mulligan (1992) asserted the mainstream nursing response to feminist scholarship has been to ignore it, and at best most nurses are liberal feminists as most “criticism in the discipline relates more to nurses’ lack of power to gain power than to the power distribution itself” (p. 173). Speedy (2000) noted that feminisms have not been adopted wholeheartedly by nurses and, in particular, ignored by practising nurses to a larger extent than nurse scholars. The contribution by nurses to feminist literature in the past has been small, which may also reflect issues of acceptance for publication (Carryer, 1995). Despite the clinical and historical ambivalence of nurses to feminisms, it has not been without numerous nurse scholars’ attempts to call for nursing to develop a significant social movement similar to that of the women’s movement (Chinn & Wheeler, 1985; Mason, Backer & Georges, 1991; Moccia, 1988; Muff, 1982; Sandelowski, 1981; Sohier, 1994; Speedy, 1991).

Reasons for a poor alliance between nursing and feminism are attributed to nursing’s historical allegiance with medicine and the medical model in the form of patriarchal entrenchment and identification with the oppressor. In addition, the divergence of nursing and feminism may be attributed to aspects of the women’s movement that at the turn of the century overlooked the value of traditional caring roles (Feldman & Lewenson, 2000). According to Shea (1990), in their striving to further women’s rights some feminists became radical, dogmatic, and elitist, and rejected or judged those (particularly nurses) who refused to abandon their traditional roles. Given public media representations that depict a stereotypical image of feminists as radical, anti-family, man-hating lesbians that have short hair, wear one earring and attend public demonstrations (Glass, 2000; Speedy, 2000;
Whelehan, 1995), the divergence of nursing from feminism exemplifies the power of dominant discourses.

David (2000) has argued rather harshly that nurses have practiced self-deception, illusion, and delusion, calling for nurses to break their mould of thinking, to create their own version of who nurse is and as cooperating allies socially construct their own context. She conjectured “nurses weave complex webs of self-deception in an effort to negotiate relationships they have with themselves, with others, and with the world at large … [which] is partially responsible for [nurses’] marginal existence” (p. 84).

Other feminist analyses of nursing by those who are nurses have often been more empathetic (Chinn & Wheeler, 1985; Davis, 1998; Delaclour, 1991; Flanagan, 1982; Glass, 1998; Heide, 1982; McInerney, 1998; Skillings, 1992; Speedy, 1991; Walter, Davis & Glass, 1999). Similarly, feminist studies of nursing by non-nurses have displayed an empathetic perspective including an ethnography of clinical practice (Street, 1992), a critical historical analysis of Canadian nursing (McPherson, 1996), and the conceptualisation of professions, institutions, and work roles (Game & Pringle, 1983; Witz, 1992). Such perspectives have sought to explain or understand nursing ambivalence to feminism including socialisation processes that have shaped the sex roles that women have accepted as entirely natural and self-evident (Weitzman, 1982). Delacour (1991) identified dominant discourses and ideology that have permeated the mass media and have both constructed nursing and operated to foreclose space for alternative representations of nursing. Commenting on the socialisation of nurses, Flanagan (1982), aptly noted

fragile self esteem, the product of female socialization makes nurses vulnerable, makes them want to identify with doctors and administrators, makes them strike out at other nurses, makes them defend and defend and defend against the realization that they as women and as nurses are devalued. (p. 184)

The gendered nature of nurses’ work with intrinsic values of caring, compassion, and relationships creates an affinity for nurses to look to feminisms for a greater understanding of their work and socially constructed context. Theories of nursing define caring practices as the central tenet or basis of nursing (Leininger, 1986; Watson, 1988). However, Falk Raphael (1996) has cautioned that caring, when considered from a feminist perspective, can be categorised into three different types. Only empowered caring encapsulates the use of power, knowledge, and ethics, compared to ordered or assimilated caring, which reflect a limited scope of caring. These latter forms of caring merely follow orders and are grounded in (male) scientific knowledge or discourse. From this standpoint it is explainable that nurses frequently report strong feelings of disempowerment when they are unable to care for patients in the manner they desire.
As nurses are predominantly women and caring is the fundamental work of nurses, feminist thought and research has much to offer nursing (Speedy, 1991). Chinn (1989) advocated that nursing’s patterns of knowing and feminist thinking have similarities that easily coalesce with the potential to empower both women and nurses. Because of women’s and nurses’ oppression which is often experienced as dual oppression, the world of nursing needs feminism (Glass, 2000). Similarly, Bunting and Campbell (1994) argued that nursing and feminism share a vision for change in the larger social system and that nursing may gain from feminism some insight to politically position itself rather than assume it was and could be uncontaminated by politics. Notions of postmodern feminism are now detailed in a more comprehensive discussion of postmodernism and poststructuralism.

Postmodernism and poststructuralism—Shifting symphonies

Beethoven’s music has in it something inaudible (something for which hearing is not the exact locality).

(Barthes, 1977 p. 152)

Postmodernity may be described as an epochal term for the period which allegedly follows modernity (Best & Kellner, 1991). This linear view of time draws debate and a complete rupture in absolute time with modernity is debated (Kenway & Watkins, 1994; Lather, 1991; Lyon, 1999; Rosenau, 1992). As well as a periodising concept, postmodernism pertains to, and is a descriptor for, the intellectual and cultural, aesthetic, and philosophical phenomena that can be distinguished from the modern (Fox, 1993; Kenway & Watkins, 1994; Lather, 1991; Lyon, 1999). Again a complete rupture with modernism has been debated by Rosenau (1992) who stated “threads of post-modern arguments weave in and out of those advanced by more conventional critics of modern social science, and so post-modernism is not always as entirely original as it first appears” (p. 5). In response to problems of modernity and to further challenge positivistic epistemology, post-modernism “proposes to set itself up outside the modern paradigm, not to judge modernity by its own criteria but rather to contemplate it and deconstruct it” (Rosenau, 1992, p. 5). In a critique of representation and nursing, Walker, K. (1994) stated “rather than dismissing ‘the real’, postmodernism foregrounds how discourses shape experiences of ‘the real’ in its proposal that the way we speak and write reflects the structures of power in our society” (p. 47). Correspondingly, Lather (1991) asserted “to write ‘postmodern’ is to simultaneously use and call into question a discourse, to both challenge and inscribe dominant meaning systems in ways that construct our own categories and frameworks as contingent, positioned and partial” (p. 1).

In a manner similar to feminisms and critical theory, postmodern theories focus on alternate meanings and discourses to dominant ideology. Postmodernisms refocus on what has been
taken for granted, the: forgotten, repressed, subjugated, rejected, silenced, excluded, marginal, deferred, peripheral, accidental, dispersed, disqualified, and all that the modern age has never cared to understand in any detail or specificity (Rosenau, 1992). However, unlike critical theory and feminism, postmodern intentions are usually not to improve, perfect, and offer alternate theories or solutions for a better world but to make modernist assumptions explicit and undermine foundational claims of modernity (Rosenau, 1992). This issue is one with which some feminists are concerned, particularly the potential lack of teleological grounding and political intent (Collins, P., 2000; Humphries, 1998; Reed, 1995). There should be intent to strive for solutions and actions with practical force to create change, rather than a purely academic venture. Cheek (2000) and Powers (1996) have refuted this reasoning, arguing that postmodern research approaches contribute to change in health care practices by providing the basis for conceptualising practice in new or different ways. Cheek (2000) asserts “if we are only interested in improving what is, it may well be that we will never explore what might be” (p. 10).

Postmodern thought is hard to define in that it does not represent a unified position or a coherent school of thought, but rather is a group of theories or positions with great diversity and often conflicting perspectives (Agger, 1991; Cheek, 2000; Lather, 1991). It is a paradox in itself to define postmodernism since it is opposed to fixed categories and absolute meanings. According to Best and Kellner (1991), “postmodern theory rejects modern assumptions of social coherence and notions of causality in favour of multiplicity, plurality, fragmentation, and indeterminacy” (pp. 4-5). Lather (1991) noted postmodernisms are responses to the contemporary crisis in representation and the uncertainty about what constitutes an adequate depiction of social reality. Nicholson (1994) characterised postmodernism as “the rejection of epistemic arrogance for an endorsement of epistemic humility. Such humility entails a recognition that our ways of viewing the world are mediated by the contexts out of which we operate”(pp. 84-85). Given these various depictions of postmodern thought, there are central or shared common notions in that “all postmodern approaches emerge from a critique of the assumptions that underpin modernist thought” (Cheek, 2000, p. 18).

Extreme and moderate approaches of postmodern thought are evident with varying interpretations according to the particular view or position taken. Kincheloe and McLaren (2000) distinguished two strands of postmodernism. Ludic postmodernism is constituted by the continual playfulness of the signifier but is limited in its ability to change the status quo. Resistance or oppositional postmodernism appropriate and extend ludic accounts with transformative and interventionist critique. Rosenau (1992) also divided postmodern thought into two general orientations or categories, but noted within these categories there was
immense variation and frequent overlapping. Sceptical postmodernists offer a negative, gloomy assessment, arguing the postmodern age is one of fragmentation, disintegration, malaise, meaninglessness, a vagueness, or even absence of moral parameters and societal chaos. Affirmative postmodernists have a more hopeful optimistic view, are open to positive political action, and many affirm an ethic and normative choice arguing certain value choices are superior to others (Rosenau, 1992). Utilising Rosenau’s classifications, the postmodern thought within this study is affirmative.

Postmodernism has been conceptually argued and utilised in research to be integrated with feminism (Calás & Smircich 1992; Dickson, 1990; Ferguson & Wicke, 1994; Flax, 1990; Glass & Davis, 1998; Heckman, 1990; McNay, 1992; Miller, S., 1997; Nicholson, 1990; Sawicki, 1996; Weedon, 1997; Wicks, 1995), as well as with critical theory and feminism (Agger, 1993; Davis, 1998; Fahy, 1997; Georges & McGuire, 2004; Heslop, 1997; Lather, 1991, 1992; McCormick & Roussy, 1997; Morrow, 1994; Uris, 1993). When integrated with critical theory or feminism, an affirmative position is usually taken congruent with the ontology and epistemology of these theoretical positions.

The terms postmodern and poststructural are often used interchangeably inclusive of Lather (1991) who noted that for definitional purposes she identifies postmodern with the larger cultural shifts of a post-industrial, post-colonial era and poststructural with the “working out of those shifts within the arenas of academic theory” (p. 4). Cheek (2000) also acknowledged that postmodern and poststructural approaches have much in common, explaining poststructural approaches as tending to focus on the exploration and analysis of texts where texts, (spoken, acted, or written), refer to representations of reality. In a similar fashion Agger (1991) commented on the difficulty of attempting to separate works that overlap and are purposefully elusive of neat categories, however, he broadly defined poststructuralism as a theory of knowledge and language whereas postmodernism is a theory of society, culture, and history. These thoughts are consistent with situating poststructuralism as a subset or part of a broader matrix of postmodern theory where postmodernism is a more inclusive phenomenon (Best & Kellner, 1991; Daniel, 1995; Fahy, 1997; Kincheloe & McLaren, 2000). The methodology of this research may, therefore, be described as either postmodern or as poststructuralist in that it explores and analyses the discourses embedded in texts (written, spoken, and acted) about managing and nurse management that are utilised to socially construct and represent reality.
Poststructuralism, humanism, and the subject  

To the beat of the drum

If you are looking about for really profound mysteries, essential aspects of our existence for which neither the sciences nor the humanities can provide any sort of explanation, I suggest starting with music .... The professional musicologists haven’t the ghost of an idea about what music is, or why we make it and cannot be human without it, or even ... how the human mind makes music on its own, before it is written down and played .... Nobody can explain it. It is a mystery, and thank goodness for that.

(Thomas, 1984, p. 162)

Poststructuralism challenges modernistic notions of humanism and individualism. Humanism traced to the Cartesian notion of splitting mind from body upholds thinking as a superior activity to doing. The philosophies of humanism and individualism arise from this modernistic notion, placing humans at the center of the world and endowing humans with the illusion of autonomy, self-control, mastery, and self-definition.

We have been seduced by humanism and individualism … [such that] we not only ignore, but play right into the hands of those who we know shape our lives, and who usually do so not with our consent but, rather with our unwitting complicity.

(Walker, 2001, p. 61)

Fox (1993) asserted that the subject of humanism, the rational, conscious, stable, unified, knowing individual, assumes the historical progress of man toward absolute knowledge and freedom and that it is possible to measure, represent, predict, and control knowledge of the social world. Modernist notions argue a knowing, disinterested, rational subject can uncover objective knowledge via a scientific method that is true knowledge (St Pierre & Pillow, 2000). Humanism posits the subject as an autonomous individual capable of full consciousness and endowed with a stable self constituted by a set of static characteristics such as sex, class, race, and sexual orientation (Lather, 1991).

Poststructuralist thought does not offer an alternative, successor regime of truth claiming to have the right answer but troubles the subject of humanism and describes the subject as one constituted within discourse and cultural practice. Poststructuralism de-centers and refashions the subject as a site of disarray and conflict inscribed by multiple contestatory discourses. The intersection of feminist and critical thought with poststructuralist notions of humanism and subjectivity is discussed later in this chapter in the section titled Integrating and negotiating the borders of critical social science, feminism and postmodernism.
Postmodern knowledge, truth, and representation  *Shifting, twisting, and intangible scripts*

The real meaning of music comes from tones only audible in the corner of the mind.

(Thomas, 1984, p. 13)

Most postmodernists reject truth even as a goal or ideal because it is the very epitome of modernity and enlightenment. Based upon order, rules, and values, and dependant upon logic, rationality, and reason, truth is associated with assumptions which are all questionable to postmodernist thought (Fox, 1993; Rosenau, 1992). Truth, according to Nietzsche (1968), was the solidification of metaphors and claims to have discovered truth when unmasked were the *will to power*. Furthermore, systems of reason and attempts at rationality are actually systems of persuasion. Human knowledge is possible only by means of language and metaphors, nomenclature, differentiation, and classification as words give rise to concepts which do not mirror reality (Schrift, 1990). Postmodern authors view language as “ambivalent, evasive, metaphorical and constitutive, rather than unequivocal, literal and depictive” (Alvesson & Sköldberg, 2000, p. 151). Jacques Derrida’s analysis of *différence* depicts the undecidability that resides in language and its continual deferral of meaning such that language constitutes meanings in terms of its difference from other things (Agger, 1991; Fox, 1993). Furthermore, logocentrism or the claim to be able to achieve an unmediated knowledge of the world (*presence*) as an indicator of authenticity, of experience of reality, and of being able to speak the truth about something and therefore claim authority is mistaken (Fox, 1993).

Modern theories tend to see knowledge and truth to be neutral, objective, universal, and vehicles of progress and emancipation, whilst postmodern perspectives view modern reason and rationality as reductive and oppressive. This nihilistic concept of a fluid and anchorless truth is usually supported by negative or sceptical postmodernists. Whilst there is a common view among postmodernist thought that reality cannot be represented and that there are multiple realities, affirmative postmodern perspectives have a more moderate perspective and view truth as local, personal, and community specific. This more moderate or affirmative position is utilised within this thesis.

Postmodern critiques are directed against the notion of theory itself which implies a systematically developed conceptual structure anchored in the real to the extent that authors such as Foucault, Guattari and Derrida, often categorised as postmodern or poststructural, refuse to classify their work within theoretical categories (Agger, 1991; Best & Kellner, 1991). Unifying or totalising modes of theory obscure the differential and plural nature of the
social field, while politically entailing the suppression of plurality, diversity, and individuality in favour of conformity and homogeneity (Best & Kellner, 1991; Fox, 1993). Lyotard (1984) defined postmodernism as the rejection of metanarratives. Rather than metanarratives, global, or grand theories, postmodernists focus on the particular and the local, applauding difference, fragmentation, discontinuity, plurality of forms of knowledge, and microanalysis. Postmodern theories critique representation, instead taking relativist and perspectivist positions that all cognitive representations of the world are historically and linguistically mediated.

Given the notion that reality is linguistically mediated, the authority of authors of postmodern texts is called into question. It is not assumed that they are, or should be, the final arbiter of meaning and the reader is no longer viewed as a passive subject. Modern authors assume privileged access to truth, reason, and scientific knowledge. They know and determine what is true whilst they simultaneously are not original as they themselves are a product of their contextual and linguistic knowledge. With modernity, the urge to represent has become obsessional and comodified with claims and methodology for valid presence seeking to represent or to know the world better than others (Fox, 1993). Extreme positions provocatively call for the death of the author (Barthes, 1977; Foucault, 1979a) as authoritorial authors are viewed as a mere instrument of power. More moderate or affirmative postmodern views attempt to reduce the author’s authority, acknowledge the author as interpreter and make no universal truth claims. These notions are inherent to this study which acknowledges, interrupts, and draws attention to the text as being an interpretation (Clifford, 1988; Lather, 2000), as well as attempting to leave endings open to a more active reading (Rosenau, 1992). Normative ambivalence, lack of moral accountability, and an absence of obligation are criticisms of the extreme or sceptical postmodern view (Reed, 1995), which are contrary to the openly ideological feminist and critical views brought to this study.

As outlined previously, this research was conducted within the context and culture of a large health care organisation. Postmodern research of organisations derives differing perspectives and explications to modernistic inquiries. Baudrillard and Poster (1988) contended seduction is dependent on the lure of withheld knowledge and the unattainable desire to be an insider. Linstead (1993) viewed organisations as multi-authored texts partially inscribing subjectivities upon actors and suggested that the simulacra of organisational identity contains within it, its own negation—the other, the suppressed that deconstructive ethnography can demystify. Carter and Jackson (1993) argued motivation within an organisation is a matter of subjective definition and that management itself is an intrinsically modernist practice unable to cope with issues of subjectivity and plural rationalities. Furthermore, the knowledge-
power nexus of the managed organisation has been increasing (Fox, 1992). According to Jackson and Carter (1992), management education has been a vehicle for maintaining modernistic views and its very discourse is shaped by considerations of creation of profit rather than concepts of play and quality of life that arise when the metatheory of management is opened to question. Clegg (1989) depicted organisations as composed of competing calculations and modes of rationality, rather than being expressive of rationality in which agencies, powers, networks, and interest are constituted.

Further postmodern organisational studies have problematised identity and reformulated the subject identifying novel spaces of resistance (O’Doherty & Wilmott, 2000). Calás and Smireich (1991) included a feminist perspective proposing leadership literature to be a seductive game with the myth of leadership embodying desire and that traditional research has imposed closure on what can be said to be organisational knowledge. Discourse analysis has been utilised by Hardy (2001), focusing on language and conceptualising societies, institutions, and identities as discursively constructed collections of texts. Following this theme, Grant, Keenoy, and Oswick (2001) argued discourse analysis identifies ways in which discursive practices are deeply implicated in the processes of organising, highlighting the role of discourse to socially construct reality for organisation members, thereby shaping and influencing organisational members’ attitudes and behaviour.

Postmodern/poststructural studies and nursing—Whistling a different tune

An increasing number of inquiries within nursing have also been informed by postmodern and poststructural perspectives identifying nursing discourses of healing and deconstructing nurses’ language (Mohr, 1999; Wicks, 1995). Cheek and Gibson (1996) described scientific/medical and legal discursive frames that shaped the role of the nurse in the administration of medication and rituals that served as mechanisms for nurses to police each other, reinforcing the notion of control and docility. Similarly, Walker, K., (1994) and Nelson (2001a) identified discourses of science and caring exposed in representational technologies and practices displaying nursing’s collusion with the truths of science and civic and patriotic discourses that framed nurses’ subjectivity. In similar studies Manias (1998), Street (1992), and Wellard (1996), combined postmodern notions from the work of Foucault with critical methodologies to provide ethnographies of nurse-doctor collaboration, clinical nursing practice, and nursing roles in home-based care. Managerialist and nursing discourses were investigated by Traynor (1999) exploring hostility between these groups within the NHS.

Postmodern and feminist theory have been integrated to develop alternate knowledges of nursing to that of medical science (Doering, 1992), of rural community nursing practice and
primary nursing (Davis, 1998), decision making in the emergency department (Arslanian-Engoren, 2002), menopause (Dickson, 1990), and endometriosis (Huntington & Gilmour, 2000). Uris (1993) explored nurses’ experience of moral madness due to the silencing of their caring by oppressive patriarchal ideology. Liaschenko (1997) identified spatial vulnerabilities such as poverty, patient exploitation, homogenisation of identity and gendered space when investigating ethical concerns of nurses. Quality and control cost rules, multiple paradoxes and complexity of the social system failing to solve the central professional problems and emerging dilemmas of nursing was identified by Spitzer (1998).

Arguments for the use of postmodern perspectives in conducting nursing research include creating the possibility of challenging existing power structures (Allen, A., 1996; Arslanian-Engoren, 2002; Crowe, 1998), to explore the effects of knowledge and power by revealing the operation of power in constructing knowledge (Boutain, 1999a; Heslop, 1997; Walker, K., 1994), and to participate in reconstructing alternative perspectives and a novel and moral direction for nursing knowledge and practice (David, 2000; Glass & Davis, 1998; Powers, 1996; Watson, 1995). Furthermore, adopting a postmodern perspective may assist nursing to untangle the conflicting agendas of global capitalism, fragmentation of care, and consumer issues which form the social world (Lister, 1997).

Many of these postmodern perspectives and analysis of nursing, culture, and organisation have utilised significant concepts and notions developed by Michel Foucault. With the exception of postmodern feminists, the work of Foucault is the most influential postmodern work utilised within this thesis. The particular Foucauldian concepts or insights appropriated within this study are now further highlighted, as these concepts rather than his methods of research were utilised within this research.

**Postmodernism and Foucault—My object oh sublime, I shall achieve in time, to make the punishment fit the crime**

> There are some pieces by Bach and Webern which I enjoy but what is, for me, real beauty is a “phrase musicale, un morceau de musique”, that I cannot understand, something I cannot say anything about.

(Foucault, 1988b, p. 13)

The work of Foucault is controversial and has been contested by authors such as Habermas from a critical theory perspective, as well as debated within feminist scholarship. Issues of political intent, the rejection of enlightenment, notions of identity, subjectivity, agency, freedom, and emancipation are central to these academic arguments. Whilst many authors take issue (Balbus, 1988; Deveaux, 1996; Hartsock, 1990), or have some reservations with Foucault’s work (Fraser, 1989; McNay, 1992), there are numerous feminist scholars who
acknowledge and applaud the contribution of his work (Heckman, 1996; Lloyd, 1996; Sawicki, 1991; Weedon, 1997). Foucault’s work has provided paradigms for thinking and opened up new paths of questioning for feminists (McCallum, 1996). Cognisant of the debates, I have appropriated aspects of his work as advocated by Allen, A., (1996). My understanding or interpretation of these aspects within this thesis is now outlined.

Academically categorised as a postmodern or poststructural scholar and philosopher, Foucault’s work has an underlying theme of the critique of modernity and philosophical questioning of who are we today (McHoul & Grace, 1993). Foucault’s major works studied the discourse/practices of insanity (1974), prisons (1977), sexuality (1979b), and deviancy and reconceptualised notions of discipline and power. He summarised the goal of his intellectual work in his last public lecture as “the necessity of excavating our own culture in order to open a free space for innovation and creativity” (Foucault, 1988a, p. 163). Some androcentrism is evident in Foucault’s discourses as they bear the traces of his own social and historical location as a male white theorist and a leading intellectual force (Heckman, 1996; Sawicki, 1991). Further feminist criticisms of his work relate particularly to his notions of agency and subjectivity whilst it is contended that his position on many concepts, whilst frequently elusive, also shifted. Broadly, Foucault’s work may be divided into three phases, with the first phase termed archaeology where he concentrated on the formation of discourses or disciplines of knowledge. The second phase, genealogy, investigated power-knowledge relations and disciplinary practices, whilst the third phase developed a theory of the self (Dreyfus & Rabinow, 1982).

Foucauldian discourses and discursive practices—Lost in the masquerade

The notion of discourse, as utilised by Foucault, is not the traditional formal linguistic or technical conversational analysis understanding of the term. It instead refers to relatively well-bounded areas of social knowledge such that in any given historical period we can write, speak, or think about a given social object or practice only in specific ways and not others (McHoul & Grace, 1993). Discourses in Foucault’s work, according to Weedon (1997), “are ways of constituting knowledge, together with the social practices, forms of subjectivity and power relations which inhere in such knowledges and the relations between them” (p. 105). Check and Porter (1997) furthered this definition in adding that a discourse in Foucauldian terms “consists of a set of common assumptions that although rarely commonly recognised, provides the basis for conscious knowledge” (p. 119). Discourses prescribe what can be said and what can be thought at a given time and act like windows selectively permitting only some things to be valued and understood, shaping our understanding of ourselves and our capacity to distinguish between issues (Danaher, Schirato & Webb, 2000). Discourses are embedded in texts, with texts being broadly defined to
include more than just literature. Discourses can be thought of as multiple, discontinuous conversations, mediated by written, spoken, and enacted texts, and separated by time and space (Foucault, 1986).

Discourses are historically and contextually mediated although they intersect and change over time. Collectively, discourses form disciplines of knowledge as demonstrated in The Order of Things (Foucault, 1970) with discourses on life, labour, and language changing to discourses within psychoanalysis, ethnology, and structural linguistics. Foucault was particularly interested in how disciplinary knowledges functioned (particularly the human sciences), and how bodies of ideas change and transform. Discursive change, however, is not linear, cumulative, rational, and necessarily progressive, getting closer and closer to the truth but discontinuous across history (McHoul & Grace, 1993). Discourses constitute what is understood or known and thereby systematically form the objects of which they speak (Foucault, 1972). Discursive practices are the “rules by which discourses are formed, rules that govern what can be said and what must remain unsaid, and who can speak with what authority and who must listen” (McLaren, 1994, p. 188). When conducting a discourse analysis within nursing it is important to examine what conflicting groups of people are saying within the discourse, who gets listened to most often and why, what the hidden agendas are, who gets chastised for their deeds or writings, how the discourse becomes widespread and to whom, and how the existence of the discourse is said to be necessary.

(Powers, 1996, p. 211)

Subjugated or marginal knowledges are described by Foucault (1980a) as “a whole set of knowledges that have been disqualified as inadequate to their task or insufficiently elaborated; naïve knowledges, located low down on the hierarchy, beneath the required level of cognition or scientificity” (pp. 81-82). Discourses, according to Foucault, are not absolute, fixed and stable, but rather fluid and relative with dominant discourses determining what counts as truth and true knowledge. The status and dominance of a discursive framework is a product of power relations such that there is an inextricable link between knowledge embedded in discursive frames and the power that enables that discourse (Cheek & Porter, 1997). Allen (1992) contended that postmodern critique in nursing notices the ways in which discourses function as regimes of power, where knowledge and power interact to normalise or legitimate specific interests.

Foucauldian notions of discourse and knowledge have been utilised within this study to identify and critique the knowledges inherent in nurses and their practice of managing and being managed. The term discourse has been utilised within this thesis to identify these bodies of knowledges and concurrent discursive assumptions. This liberal use of the term in
this study, however, transgresses from utilising the full archaeological method articulated by Foucault.

**Power, knowledge, and truth** *You don’t know like I know*

Commensurate with postmodern thinking, Foucault was sceptical regarding notions of absolute truth and sought instead to show people that they were freer than they felt, “that people accept as truth, as evidence, some themes which have been built up at certain moments during history, and that this so-called evidence can be criticized and destroyed” (Foucault, as cited in Martin, 1988, p. 10).

Foucault linked truth with power and knowledge noting that it was always context specific.

Each society has its régime of truth, its ‘general politics’ of truth: that is, the types of discourse which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; [and] the status of those who are charged with saying what counts as true.

(Foucault, 1980c, p. 131)

As Foucault’s work proceeded, his emphasis shifted from archaeology to genealogy, concentrating on the relations of power, knowledge, and the body in modern society. Following the work of Nietzsche, Foucault focused on the play of wills, subjection, domination, combat, and strategy that exist in a network of relations, constantly in tension in activity (Foucault, 1977). This structural field of clashes or battle of domination is fixed in rituals of power that prescribe rules, obligations, universal laws of humanity, and moral codes. Interpreting Foucault’s arguments in his earlier work, Dreyfus and Rabinow (1982) asserted “history is not the progress of universal reason but the play of rituals of power, of humanity advancing from one domination to another” (p. 110).

These rather negative views of humanity, power, and coercion depicted in his early works have been contested by many feminists (Balbus, 1988; Bartky, 1988; Deveaux, 1996; Hartsock, 1990, 1996; McNay, 1992) asserting Foucauldian thinking as nihilistic, that agency is removed from the subject, the concept of power is androcentric, and that there is a failure to articulate processes for empowerment. His later works are preferred by many feminists as they provide a more positive appraisal of social life, including the notion of subjectivity and agency.

The writings of Foucault and Habermas have similarities in their commitment to the critique of power and the pathological consequences of the operation of state welfare bureaucracies (Outhwaite, 1996). However, Foucault’s notion of power departed significantly from traditional views in that power was not owned or held by a privileged person or group, was

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not simply the domination of the weaker by the stronger, but rather a force field of relations and inextricably tied to knowledge. Foucault (1977) argued “power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations” (p. 27). Two other significant aspects of power were articulated by Foucault. Rather than a relationship between a sovereign (the state) and a subject, power in modern society is concerned with the management and administration of life processes (McHoul & Grace, 1993). The mechanisms of power are historically specific with each society having quite specific practices, as there are no necessary or universal forms for the exercise of power to take place (McHoul & Grace). Further to this, power is not primarily negative and repressive. What gives power its hold and makes it accepted is its productive force. According to Foucault “we must cease once and for all to describe the effects of power in negative terms: it “excludes”, it ‘represses’, it ‘censors’ … power produces; it produces reality; it produces domains of objects and rituals of truth” (1977, p. 194).

Foucault’s notion of power is that of capillary power rejecting the top-down approach of those with power oppressing those without power and instead conceptualising a network of power relations. This is significant, for in understanding how power operates and its effects, rather than attempting to think we can ‘progress’ to a powerless society, nursing can work ‘with’ rather than ‘against’ it (Cheek & Porter, 1997).

Foucault’s notion of power has often been utilised by poststructural feminists who seek an analysis of power that is alternate to traditional models and that provides for the possibility of productive sites of resistance and alternate subject positions. Feminist thought frequently redefines traditional views of power. Hartsock (1983) and Shewsbury (1987) viewed women’s notions of power as concerning and emphasising energy, capacity, and potential, rather than domination and exclusion. Furthermore, it is utilised as a way to accomplish ends. Sohier (1994) advocated for the power of the weak utilising feminist notions of collective bonding, self-knowledge, and sisterhood to develop a pacifist nursing community with strength. Lind, Wilburn, and Pate (1986) similarly described the concept of power with rather than power over for nurses; that power can exist on a horizontal plane encouraging cooperative rather than competitive relationships. Chinn (2001) further affirmed the feminist importance of cooperation as a vital element in any exercise of power so that power is shared and becomes empowerment. Benner (1984) related this to clinical nursing defining a masculine view of power as emphasising “competitiveness, domination and control …. The disparagement of feminine perspectives on power is based upon the misguided assumption that feminine values have kept women and nursing subservient, rather than … society’s devaluing of and discrimination against women” (pp. 207-208). Attridge (1996) described
nurses’ conceptions of power as “the ability to have control over my work situation [to] … successfully bring about more effective patient care … [rather than] the more traditional power literature which speaks of power as control over others as an end in itself” (p. 50).

Normalisation, inciting desire, and attaching individuals to specific identities is the disciplinary productive power described by Foucault, rather than power being conceptualised exclusively as negative, repressive, and violent (Sawicki, 1991). Similarly, desire according to Foucault, is socially constructed in a positive rather than repressive manner and is intrinsically linked with discourses and knowledge that construct and incite in self what is deemed desirable. Disciplinary power, according to Foucault, utilises instruments and techniques that can be adopted by any institution and involves coordination of techniques with systems of knowledge. The term discipline designates not only the training techniques but the forms of knowledge that developed alongside of them (McHoul & Grace, 1993). The clinical gaze conceptualised by Foucault linked spatial notions with the body, subject, and power/knowledge. Powers (1996) stated “a gaze is a productive way of looking at a pre-determined site constructed by a discipline through discourse, and creates power/knowledge to be wielded by the accepted membership” (p. 213).

These notions of spatiality, observation, and perception were extended by Foucault (1977) in the form of a disciplinary technique being self-surveillance; an effect of the panoptican. The panoptican an architectural apparatus allowed for the continual observation of prisoners whilst requiring few supervisory resources, such that a mechanism was created for sustaining a power relation independent of the person exercising it (McHoul & Grace, 1993). Surveillance and the internal training this produced incites states of docility without overt displays of force (Foucault, 1977).

According to Foucault (1977), discipline proceeds in four major ways, with the first being spatial distribution, that is, enclosure or partitioning certain groups of people from others, or by a network of relations of rank so that one knows ones place. The second way is in the control of activities and the extraction of time and labour from the body. The third way discipline proceeds in the organisation of segments or stages of training. There is a general code for the transition from student to master with segments codified in terms of hierarchy so that the development of skills can be carefully monitored and individuals or novices may be differentiated.

Lastly, there is general coordination of all the parts into more general machinery so that the product of the various forces is increased by their calculated combination (Foucault, 1977). Foucault utilised the term bio-power to encompass the discipline of individuals with associated disciplinary techniques such as the panoptican.
The confessional, similar to the panoptican, became a technology of power, regarding which he claimed

in justice, medicine, education, family relationships, and love relationships, in the most ordinary affairs of everyday life, and in the most solemn rites; one confesses one’s crimes, one’s sins, one’s thoughts and desires, one’s illnesses and troubles; one goes about telling, with the greatest precision, whatever is most difficult to tell … Western man has become a confessing animal.

(Foucault, 1979b, p. 59)

The confessional as a technology of power, links power with knowledge and the production of knowledge. As a technology applied in institutions of society, the confessional enabled different sorts of knowledge about the subject to be harnessed which was interpreted and reconstructed by those classified as having the authority. According to McHoul and Grace (1993) “the confessional can take the form of interrogations, interviews, conversations, consultations or even autobiographical narratives” (p. 80). In this context the interviews conducted for this study can be viewed as confessional. One confesses to “the authority who requires the confession, prescribes and appreciates it, and intervenes in order to judge, punish, forgive, console, and reconcile” (Foucault, 1979b, p. 62).

Similar to the confessional, the notion of the examination was described by Foucault as a technique that brought surveillance and normalising judgements together. Discipline was directed primarily upon individual bodies, with the body viewed as both object and instrument. Hierarchical observation or surveillance was spatially organised to ensure constant high visibility of the object and yet power itself rendered invisible. Individualisation of the body occurred in descending hierarchical order and normalising judgements were necessary in order to have a standard that unified operations and to specify and solidify appropriate punishment (Dreyfus & Rabinow, 1982). This process eventualised in normalising judgements being applied to minute aspects of everyday behavior. The examination provided for the compilation of minute information such that the child, the patient, the criminal, are known in infinitely more detail than are the adult, the healthy individual, and the law-abiding citizen (Dreyfus & Rabinow, 1982). Furthermore, the systematic collection and ordering of knowledge by the authorities allowed for the modern individual to be objectified, analysed, and fixed in written representations.

Technologies of the self and governmentality  Conduct and aesthetics

Foucault’s later work moved to an interest in an aesthetics of the self which permitted the explication of his notions of subjectivity and alternate possibilities of existence more fully than in his previous work. It was contended that his position also altered in these works (Danaher et al., 2000).
Foucault further argued
to analyse the genealogy of the subject in Western civilization, one has to take
into account not only the techniques of domination, but also the techniques of
self. One has to show the interaction between these two types of the self.

(Foucault, as cited in McNay, 1992, p. 49)

Foucault linked self-knowledge, self-mastery, and truth with aesthetics. He contended “the
transformation of one’s self by one’s own knowledge is, I think something close to the
aesthetic experience” (1988b, p. 14). Whilst still maintaining that subjectivity was shaped by
the historical and cultural context, Foucault described human nature not as an authentic
natural self, but that it changed in different places and times according to the culture that
shaped what could be said, thought, and done. Foucault insisted it was possible to identify
some of the regulatory mechanisms and discourses, and to work on ourselves or reproduce
ourselves as subjects better fitting for living with the self and with others (Danaher et al.,
2000). Foucault (1984a) contentiously stated “from the idea that the self is not given to us, I
think that there is only one practical consequence: we have to create ourselves as a work of
art” (p. 351).

This notion of self as a work of art has, however, been criticised for privileging taste and
beauty over intellectual or moral virtues, for being self-indulgent to those who have time and
money, and for depoliticising people by focusing on the private self rather than engaging in
wider social activities (Danaher et al., 2000). Furthermore, style and aesthetics are often
inadequate concepts to explain clearly the relation between particular practices and its
sociocultural determinants, particularly in relation to gender (McNay, 1992).

This view of self, however, is consistent with Foucault’s notion of power as an unstable field
of social relations so that “as soon as there’s a relation of power there’s a possibility of
resistance. We’re never trapped by power: it’s always possible to modify its hold” (1980b,
p. 13). Within a field of struggling power relations, no single authorised truth ever emerges
and stays fixed. As power operates at the micro level of society so “resistance must be
carried out in local struggles against the many forms of power exercised at the everyday
level of social relations (Sawicki, 1991, p. 23).

Within Foucault’s work, technologies of the self are also linked to his notion of
governmentality. The art of government is both about governing self and the relationship to
others. Governmentality links notions of self-government to the more global issues of the
government of populations, particularly through the concept of subject formation.
Governmentality is “the ensemble formed by the institutions, procedures, analyses and
reflections, the calculations and tactics, that allow the exercise of this very specific albeit
complex from of power, which has as its target population” (Foucault, 1979c, p. 20). Foucault also argued this government could be resisted through techniques of self-government.

Governmentality implies the relationship of self to self, which means…the totality of practices, by which one can constitute, define, organise, instrumentalize the strategies which individuals in their liberty can have in regard to each other. It is free individuals who try to control, to determine, to delimit the liberty of others and, in order to do that, they dispose of certain instruments to govern others.

(Foucault, 1994, p. 19)

The constitution of the human subject is important in governmentality linking this notion with discourse, truth and technologies that shape human subjectivity as well as the techniques by which human beings judge and act upon themselves. Rose (1999), utilising the work of Foucault, mapped the growth of the discipline of psychiatry and its relationship with contemporary subjectivity. Rose states “psychological expertise now holds out the promise not of curing pathology but of reshaping subjectivity” (p. xxxi). He further conjectured work becomes an essential path to self-fulfilment as psychologists of organisations and occupations have colluded in the invention of more subtle ways of adjusting the worker based upon the happy but not altogether illusion that industrial discontent, strikes, absenteeism, low productivity and so forth do not derive from fundamental conflicts of interest but from ameliorable properties of the psychological relations of the factory.

(Rose, 1999, p. 58)

Foucault and Rose concurred that modern selves have become attached to the project of freedom, truth, and self-knowledge and in so doing have subjected themselves to governmental technology and the bureaucratic management of life itself.

On a more positive note, Foucault (1977) asserted “thought is freedom in relation to what one does, the motion by which one detaches oneself from it, establishes it as an object, and reflects upon it as a problem” (p. xxxv). From this, an individual is as free as far as they can possibly reflect and imagine in thought, given that thought is constructed from language which is culturally mediated.

Foucault moves to a position that is transgressive politically and offers up the chance of reinvention of alternate selves. The Foucauldian conceptualisation of the notions of discourse, power, truth, technologies of the self, and governmentality are important facets of this research. As many of these notions and the implications for research are contentious, I valued clarifying my understanding or interpretation of these notions as utilised within this research. Foucauldian notions of discourse and power are more commonly utilised in research than the later concepts of technologies of the self and governmentality, yet it is in
these latter concepts that the notions of subjectivity and agency are more fully explicated. I agree with McNay (1992) that the concept of aesthetics of existence is underdeveloped, however, the concept of reinvention is highly valuable for feminist and critical research.

Utilising the work of Foucault in this research to investigate experiences of nurses being managed and managing, I was particularly interested in what were the effects of truth produced within dominant discourses and what were the resistant discourses of nurses to the truths. I sought the extent to which nurses were immersed in, constituted, and resisted the dominant discourses and their ability to identify with other discourses. I was also interested to observe and seek out the everyday practices, rituals, activities, and effects of discourse embedded in nursing management within the organisation and institutional context and how these related to the larger social context of the nurses’ lives.

The notions of subjectivity, identity, and agency have been particularly contested and debated within feminist literature, including the interpretation and implications of how Foucault conceptualised these notions. My interpretation of these interrelated concepts is now explicated in the intersection or integration of critical, feminist, and postmodern thought and is inclusive of the notion of mobile subjectivities.

**Integrating and negotiating the borders of critical social science, feminism, and postmodernism**  
*The triple concerto*

*Ok, now let’s do theory.*

(Flax, 1999, p. 10)

For the purposes of clarity, the paradigms of critical social science, feminism, and postmodernism have, until this point, predominantly been discussed separately. Their integration or the *space between*, however, is intrinsic to this thesis. My interpretation of integration is not so much the recruitment of three discrete bodies of knowledge and fastening of them together, but to discern and highlight the areas of overlap, discord, and uncertainty in these paradigms of thought and to conceptualise or interpret them from my own particular authorial position. There are, therefore, two aspects to this interpretation or representation. Firstly the notion of combining questionably discrete paradigms, and secondly, the notion of the authorial position.

In respect to the paradigms, I do not view them as discrete bodies unless the standpoint is taken from the extreme position of each. From this extreme view the categorisation marks a distinct linear rupture or sense of spatial separation between each paradigm. However, they can also be viewed as having a rather fluid or somewhat extending space of continuity between, around, and overlapping each position. This may be likened to Deleuze and
Guattari’s (1987, p. 382) notion of “smooth space” that gnaws and tends to grow is all directions like the desert, the sea, the air (St Pierre, 2000). The previous explication of the three paradigms, whilst attempting clear categorisation, displayed marked areas of convergence and similarity. For simplicity it would be convenient to locate an exact point of ground where each position overlapped and met or to identify a recipe style method of proportionment (Ferguson, 1993). It would, however, still assume an artificial boundary or the ability to delineate exactly a boundary or portions of knowledge. The assumption of a fixed point or object that can be triangulated assumes a rigid, fixed two dimensional object of plane geometry rather than multidimensionality, refraction, and transmutation (Richardson, 2000). Trinh (1989) also validly stated that “despite our desperate and eternal attempt to separate, contain, and mend, categories always leak” (p. 94). The three paradigms, therefore, are combined in this thesis fluidly so that whilst emphasis is given to areas or spaces of convergence, spaces of discord and disharmony are also highlighted and arbitrary boundaries are transgressed.

The notion of the authorial position is the other aspect important to explain the theoretical stance of this thesis, and particularly the representation of data. Given that this thesis is a representation and my position as author is also that of a human subject, I acknowledge that I also have a distinct subjectivity. Whilst most traditional academic work is written from the notion of a stable, fixed, static subject, the notion of human subjectivity (including my own) inherent in this thesis is consistent with many feminist works that, utilising different articulations, have viewed human subjectivity not to be fixed but to be fluid, mobile, and shifting. Ferguson (1993), utilising the term mobile, described this notion of subjectivity to be temporal, moving, and shifting. Haraway (1990) also described subjectivity to be contradictory, partial and strategic, similar to Boker (1999) who described the potential postmodern feminised self as flexible and fragmentary. Whilst my subjectivity as author is fluid, un-fixed, and mobile, this is not so say that my views and thought (subjectivity) as author are totally incongruent or completely inconsistent, rather they are not rigidly fixed to an exact finite point within a walled theoretical category. The movement in my subject positions often raises points of contention and conflict which coincides with the search or exploration of questions, problems and contradictions, including seeking alternate views or troubling apparent given constructs. This fluidity or mobility of my subject position also arises from the very discourses (knowledges and practices) that construct my own subjectivities which at times compete, contest, and are disparate, whilst at other times they mutually coexist or complement each other in agreement. My subjectivity or position as author moves back and forth within the theoretical positions previously explicated, at times however being troubled and also simultaneously troubling the theoretical boundaries.
The issue of representation has led feminist authors working within postmodern paradigms to attempt alternate methods for presenting and representing their work. Lather (2000) utilised narrative with interruption (angels) as a technique for enabling her to give voice to the narratives of participants whilst also attending to the crisis of representation. Lather described her work as a kind of rigorous confusion and “research that makes a difference in struggles for social justice while working against the humanist romance of knowledge as cure within a philosophy of consciousness” (pp. 305-307). Czarniawska-Joerges (1994) also utilised interruption as a technique to subvert interpretation. Utilising electronic on-screen hypertext described as a poetics of postfeminist research, Morgan (2000, p. 132) represented Lather’s work, drawing on nomadic thinking and rhizomatic text to “represent the condition of social science knowledge as unstable … contextual and relational … and provisional” blurring the boundaries between author and reader. Similarly, Alvermann (2000) utilised Deleuze and Guattari’s (1987) notion of rhizoanalysis to represent data from a previous study to connect disparate phenomena in ways exceeding what is typically regarded as naturally real.

Davis (1998) and Natoli (1997) utilised the strategy of dialogue or a conversation with narrative intent depicting multiple voices with the aim of interrupting and subverting the standard ethnographical text. Within her ethnographic research Richardson (1992) utilised sociopoetics (data in poetic form) to challenge the issue of authorial authority. Richardson noted this highlighted the intersection between the subjectivity of the author and that of the participant. The author, however, was still portrayed as the owner of a stable subjectivity. In depicting my own mobile subjectivity and representing the thesis in this manner, it permitted me to be able to articulate the complexity of my own subjectivity. My tentativeness, turmoil, and yet, at times, ease in integrating the three paradigms allowed for my desire to have a critical intent, provided space for nurses and women to voice their experiences, and simultaneously acknowledged this thesis still to be my representation of a complex and arbitrary truth.

Lather (1991) argued that rather than collapse theoretical moments into a spurious synthesis, instead we create a weave of knowing and not knowing as in these parallels and differences we move toward a future transcending present limitations. Conventional social scientific writing should not be held sacrosanct as writing styles and representations have been blurred, enlarged, and altered in the wake of postmodernism in what may be termed creative analytic practices (Richardson, 2000). In the following section I further elaborate on the notions of subjectivity, identity, agency, and mobile subjectivity, relating them to my application within a critical, feminist postmodern ethnography.
The tensions of subjectivit(ies), identit(ies), and agency  Playing with tension

The notions of subjectivity, identity, and agency are frequently interrogated within feminist poststructuralist work and are often the site of contention between feminist poststructuralists and those that adhere to the critical or non post feminist paradigms. It could be described as a struggle over the subject. Rather than a dualistic discussion of the binary oppositions of the issues within these paradigms, the tensions, contradictions, and overlaps regarding subjectivity, identity, and agency are considered. Related issues of humanism, essentialism, difference, and experience are also inherent to this discussion. Binary oppositions invariably absorbs alterity into the hegemonic and familiar such that this type of thinking merely involves the juggling of traditional categories privileging some at the expense of others and without changing the power structures behind such constructions (Gunew & Yeatman, 1993).

Subjectivity  Playing from the soul or script

Feminist poststructuralist perspectives challenge the discourses of emancipation and the assumptions of fixed identity and a unified, rational, subjectivity found in some feminist and much critical literature (Ormer, 1992). According to Weedon (1997), subjectivity refers to

the conscious and unconscious thoughts and emotions of the individual, her sense of herself and her ways of understanding her relation in the world.

Humanist discourses presuppose an essence at the heart of the individual which is unique, fixed and coherent and which makes her what she is … poststructuralism proposes a subjectivity which is precarious, contradictory and in process, constantly being reconstituted in discourse. (p. 32)

Poststructuralist accounts aim to denaturalise humanism and assert that subjectivity is constituted by discourse and historical context. Butler (1992) states

it is clearly not the case that “I” preside over the positions that have constituted me, shuffling through them instrumentally, casting some aside, incorporating others, although some of my activity may take that form. The “I” who would select between them is already constituted by them … and these positions are not merely theoretical products, but fully embedded organizing principles of material practices and institutional arrangements, those matrices of power and discourse that produce me as a viable ‘subject’. (p. 9)

Differing conceptions of subjectivity dispute the notion that subjectivity is completely constituted. Feminist analyses often imply a central core of self or subjectivity, although most feminist thought attempts to refuse the fixed unchanging traits echoed in male-ordered arguments. Many cosmic feminists stress the self in relation to a larger natural or spiritual order, including a soul-orientated subjectivity that appeals against the self-interest enshrined

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in modernity (Ferguson, 1993). Participation in, rather than domination of, the natural world is consistent with the critique of modernity and logocentric thinking. Ferguson (1993) also identified praxis-orientated feminists who focus on needs and persons-in-relations to articulate women’s experience and ways for reconstituting individual and collective life arguing they often theorise all women as a category with a set of essential attributes.

Fahy (1997) clearly articulated a belief in an inner self, who is “protected from the distortions of taking on the masks of multiple, culturally available subject positions. The self … is a priori, natural and innate …. This belief in the inner or true self is consistent with … conceptions of the soul and the spirit” (p. 30). Watson (1999) argued nurses have been estranged from their sacred feminine creative energy and that the body is the instrument of the spirit. She also denoted a concept of identity whereby humans are spiritually interconnected and “all is one … [and to] consider those who are different from us to be less than us … [is to] create conflict within our spirit” (p. 163). Similarly, Heckman (1999, p. 23) stated “I did not experience myself as choosing to adopt feminism rather than some other identity I might have chosen, but, rather, as a logical extension of a pre-existing ‘I’” (p. 23).

McNay (2000) whilst not completely contesting the social construction of subjectivity, developed a generative account of an imaginative or creative substrate to action. She contended this agency explains “how when faced with complexity and difference, individuals may respond in unanticipated and innovative ways which may hinder, reinforce or catalyse social change” (p. 5). Similarly, Heckman (1999) also advocated for some middle ground, arguing that social constructionist theories of identity can be adapted to feminist needs whilst she simultaneously asserted we should be aware of the experiential dimension of identity. In stark contrast, Butler (1992) has refuted this experiential dimension of identity arguing

the subject is constituted through exclusion and differentiation, perhaps a repression, that is subsequently concealed, covered over, by the effect of autonomy …. The autonomous subject can maintain the illusion of its autonomy insofar as it covers over the break out of which it is constituted. (p. 12)

It has been similarly argued that experience is so much a part of everyday language that we need to insist of its discursive nature as it is always already an interpretation and something that needs to be interpreted (de Lauretis, 1984; Scott, 1991; Spivak, 1987). Scott (1991) stated

when experience is taken as the origin of knowledge, the vision of the individual subject (the person who had the experience or the historian … ) becomes the bedrock of evidence on which explanation is built. Questions about the constructed nature of experience, about how subjects are constituted as
different in the first place, about how one’s vision is structured—about language (or discourse) and history—are left aside. (p. 777)

The notion of self has also been explored by Gergen and Gergen (1988) who problematised the traditional individual trait, personal characteristics or mental processes approach to self and identity and instead advocated a view of relational forms of self. Selves or self narratives are multiple and are not the possession or property of the individual but are the products of social exchange or the manifestation of relationships. The individual makes sense of life events by constructing a self-narrative that is in continuous fluid motion undergoing continuous alteration. These selves, self-narratives or constructions are “properties of social accounts of discourse” (Gergen & Gergen, 1988, p. 19). Barclay and Smith (1993) proposed a similar notion of remembered selves formed in thought and language and shaped by cultural practices.

Given the above accounts I am reticent to release my notion of an essential core or soul that shapes my subjectivity, but I also resonate with the poststructuralist arguments of Butler (1992) and Scott (2001). Whilst acknowledging that subjectivity is, to a large extent, shaped by social construction, thinking about identity only as a series of repeated transformations is personally confronting and situates me in a position of questioning tension. The latter part of Scott’s work is less deterministic and provides a mechanism for agency and political change. Scott described identity formation from the perspective of possible coalitions of commonality (despite differences) and that subjects transcend the specificity of their circumstances through the simplification fantasy provides (imagined resemblances of commonality) such that political change is possible. This resounds closely of the ability to imagine, choose, or extract from choices of narratives of knowledge or competing discourses. On these accounts of subjectivity, my knowledge swings (is mobile) from the notion of an essential core of subjectivity to that of subjectivity and identity being completely (in constant transformation) socially constructed. As the above discourses compete and rather than foreclose, I am open to differing and further accounts of subjectivity. My subject position or subjectivity in relation to this aspect is mobile, however, I also recognise that rather than viewing these positions as dualistic and in opposition, subjectivity may well encompass a core soul or spirit that is overlaid and interwoven with discursive constructions of identity. A constituted subjectivity, however, does not predicate lack of agency, which is now further discussed.

**Agency  I want to break free**

Similarly to Scott (2001), Butler (1992) attested that to claim the subject is constituted is not to claim it is determined.
The constituted character of the subject is the very precondition of its agency … agency is always and only a political prerogative … if the subject is constituted by power, that power does not cease the moment the subject is constituted, for that subject is never fully constituted, but is subjected and produced time and again …. [There is] the permanent possibility of a certain resignifying process … power’s own possibility of being reworked.  

(Butler, 1992, pp. 12-13)

This notion draws upon, and is consistent with, Foucault’s later notions of subjectivity, agency, and resistance. As Heckman (1999) explicitly stated “socially constructed selves are not social dupes, but agents who act and resist” (p. 21). Laclau and Mouffe (1985) similarly confirmed this possibility for change in their critique of hegemony, advocation for pluralism, and polysemic resistance and rejection of the notion of a universal class. Laclau and Mouffe contend “there is nothing which permanently assures the stability of an established [social] order” (p. 169). Affirmative postmodern, critical, and feminist thought have a distinct area of convergence in their notion for human subjectivity to be capable of reflection, choice, and therefore have some degree of agency. Whilst the positions are sceptical of male reason and universal rationalism, the subject is afforded the ability to act and make contextual choices.

Given that subjects are formed through exclusionary operations (Scott, 1988), and that domination works through the regulation and production of subjects, the question of fixing any identity or of creating any essentialist categories is seriously questionable. Identity categories are never merely descriptive but always normative and, as such, exclusionary. Butler (1992) asserted

If feminism presupposes that ‘women’ designates an undesignatable field of differences … then the very term becomes a site of permanent openness and resignifiability … emancipat[ing] it from the maternal or racial ontologies to which it has been restricted …. If its referent is not fixed then possibilities for new configurations of the term become possible … expanding the possibilities of what it means to be a woman … [that] enable an enhanced sense of agency.  

(Butler, 1992, p. 16)

**Centering or decentering the subject and humanism—Soul kinda feeling**

The dilemma for many feminist theorists in aligning their feminist work with poststructuralism is that of centering the subject (primacy of voice) and therefore utilising an interpretive lens, or of decentering the subject (subjectivity as socially and historically constituted), and therefore working within poststructuralism (Ferguson, 1993). Critical perspectives of subjectivity share with most feminist accounts the centering of the subject. Lived realities and the material conditions of the lives of the oppressed should not be obscured by a preoccupation with philosophical aspects of a discipline and are linked with strategies for intervention (Humphries, 1998). Ferguson, however, asserted to transcend and
draw the best points from each mode of inquiry assumes a narrative of progress toward a higher unity and instead advocated to highlight “contradictions that do not resolve … [and to keep] the tension of holding incompatible things together because both or all are necessary and true” (p. 30). Similarly, Fuss (1990) advocated not taking sides in this debate so as to benefit from problematising the issue.

Aligned with the notion of centering the subject, the issue of humanism is contentious both within feminist theories and between that of poststructuralism. Liberal and radical feminisms (assuming a distorted subjectivity) uphold humanist notions of the sovereignty of the individual and that the individual subject is the source of self-knowledge with a consistent stable subjectivity (Weedon, 1997). Johnson (1994) contended that “feminism is a humanism …. Each time a feminist theory raises … a principled commitment to the idea of the autonomy, the unique and rightful diversity of feminine selves, it speaks in the language of humanist values” (p. 134). Fahy (1997) similarly argued “that it is difficult, if not impossible, to be both feminist and anti-humanist. Feminists value human freedom, autonomy and self-conscious reflexivity; these are humanistic values that imply an inner, authentic subject” (p. 30).

Postmodern accounts and many feminist accounts (Orner, 1992; Weedon, 1997) refute humanism and grand narratives and attempt to denaturalise the world that humanism naturalised (Jardine, 1985). They contend that Hegelian notions of humanism, apart from equating with maleness, constitute the self as a walled city, as the center of all things, as completed and self-defining and concerned with domination (Ferguson, 1993). Whilst poststructural accounts renounce Hegel’s notion of domination, the conception of subjectivity within poststructural accounts similarly contends that subjectivity is discursively created through exclusionary and negation processes. I concur with Fahy (1997) who argued much of the debate centers around the particular meaning given to humanism and that present day humanists acknowledge the need to value human plurality and difference. Furthermore, many poststructuralist theorists espouse values that are not far from the values of contemporary humanists. Given the intention to reject or suspend all grand narratives, (Foucault, 1981) notes difficulty in escaping from Hegel. Lather (1991) pertinently also cautioned not to replace the old master narratives with the essentially male postmodern narratives as new master discourses.

The politics of identity—Singing soloist and with the choir

This tension in respect to identity and politics within the paradigms is again viewed in the differing critiques of Foucault’s work. A risk identified by Sawicki (1991) is the issue of self-erasure and self-refusal or the need to think against one’s identity. Sawicki asserted this

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as a risk only aligning this with de Lauretis’ (1990) notion of dis-identification with femininity or dislocating and leaving home when in a patriarchal society no real home exists. Alternatively, Hartsock (1996) and Kaplan (1987) have asserted concern that the feminist voice, authority, identity, theoretical homes, and personal narratives are necessary for women’s awareness of themselves and as an oppositional women’s movement. Sawicki contended a balance or tension must exist between strategic identity formation yet dis-identification to prevent identity closure. Butler (1992) also noted this strategic or political use of identity whilst maintaining “the rifts among women over the content of the term [woman] ought to be safeguarded and prized, indeed, that this constant riftting ought to be affirmed as the ungrounded ground of feminist theory” (p. 16). Haraway (1991) eloquently summated this utilising the terms of affinity and nodes of connection suggesting the utilisation of “partial, locatable, critical knowledges sustaining the possibility of webs of connections called solidarity in politics and shared conversations in epistemology” (p. 91).

A further tension is evident between notions of critical, postmodern, and feminist perspectives related to consciousness raising. Weedon (1997) asserted consciousness raising in feminist practice is a method for collectively examining experience which, when voiced and reflected upon, may lead “to a recognition that the terms in which we understand things are not fixed” (p. 81), and may elicit contradictions or assumptions in women’s lives leading to alternate conceptions of the meaning of that experience. Hollway (1989), adhering to the Foucauldian notion of discourse, also advocated consciousness raising as a method for eliciting alternate discourses. However, a poststructural view is concerned with the notion of experience and a search for truth. Orner (1992) stated “in a Foucauldian framework, the talking circle represents an expression of disciplinary power-the regulation of the self through the internalization of the regulation by others” (p. 83).

Tensions exist in these perspectives, however, congruencies and similarities are also evident. The critical intent and ability of subjects for agency is an area of congruence and is reflected within this study. The agency of the subject “lies precisely in its ongoing constitution—the subject is neither a ground nor a product but the permanent possibility of a certain resignifying process” (Butler, 1992, p. 13). Foucault (1977) advocated criticism to investigate

the events that have led us to constitute ourselves and to recognise ourselves as subjects of what we are doing, thinking, saying .... Thought is freedom in relation to what one does, the motion by which one detaches oneself from it, establishes it as an object, and reflects upon it as a problem. (p. xxxv)

As such subjects, we are thinking individuals whose freedom lies in our ability to reflect, critique, think, and imagine.
The notion of subjectivity as being nonunitary, shifting, or mobile is now explored. The strategy of positioning myself as an author with a subjectivity that is nonunitary, fluid, and mobile allows for these different, yet sometimes complementary positions, to each be articulated and explored without synthesis to one common truth. Haraway (1990) contended “the political struggle is to see from both perspectives at once because each reveals both dominations and possibilities unimaginable from the other vantage point. Single vision produces worse illusions than double vision or many headed monsters” (p 196).

**Subjectivity and mobile subjectivities  Polvocality**

Poststructuralist accounts refute the notion of the unitary rational subject and view the subject as constituted by multiple subjectivities or subject positions. The notion of mobile subjectivities utilised within this research is that described by Ferguson (1993) who stated mobile subjectivities are temporal, moving along axes of power … without fully residing in them. They are relational, produced through shifting yet enduring encounters and connections, never fully captured by them. They are ambiguous; messy and multiple, unstable but persevering …. They respect the local, tend toward the specific … [and] are politically difficult in their refusal to stick consistently to one stable identity claim; yet they are politically advantageous because they are less pressed to police their own boundaries. (p. 154)

The notion of subjectivity being nonunitary has also been described by other feminist authors. Haraway (1990) described subjectivity to be contradictory, partial, and strategic (cyborgs) and of situated knowledges (1988), Buker (1999) depicted the potential postmodern feminised self as flexible and fragmentary (pucks), and Minh-ha (1986/1987, p. 9) described a subject who “moves about with always at least two/four gestures” and refuses any one a priori coherent narrative. Henriques, Hollway, Urwin, Venn, and Walkerdine (1984) viewed the subject as composed of “a set of multiple and contradictory positionings or subjectivities” (p. 204). De Lauretis (1990) described eccentric subjects and subjectivity as an ongoing construction rather than a fixed point of departure or arrival. Mouffe (1993) reconfigured “the individual … as constituted by an ensemble of ‘subject positions’, participating in a multiplicity of social relationships … [and] a plurality of collective identifications” (p. 85). Davies (1994) also explained a migratory subjectivity as the subject’s agency to cross borders, journey, and migrate so as to refuse being subjugated. Similarly, Braidotti (1995) conceptualised nomadic subjectivity and consciousness as a total dissolution of the notion of a center and consequently originary sites of authentic identity. Reinharz (1998, as cited in Gergen & Gergen, 2000) described herself as selves emergent through the process of immersion in the field with different layers being uncovered and unpeeled. Trinh (1989) described “‘I’ is, therefore, not a unified subject, a fixed identity, or
that solid mass covered with layers of superficiality one has gradually to peel off before one can see its true face. ‘I’ is, itself, infinite layers” (p. 94). Marshall and Wetherell (1989) also stated “there is no one ‘true’ representation of self and identity. At any given moment there will be varying possibilities for self construction .... Identities are actively negotiated and transformed in discourse and ... language is the area where strategic construction and reconstruction of self occurs” (p. 125).

Davies and Harré (1990) asserted the notion of position “as an appropriate expression with which to talk about the discursive production of a diversity of selves” (p. 47). Positioning is the vantage point a person sees the world from “in terms of the particular images, metaphors, story lines and concepts which are made relevant within the particular discursive practice in which they are positioned” (p. 46). Furthermore, each person comprises a multiple selfhood which is discursively constituted and is “that aspect of self that is involved in the continuity of a multiplicity of selves” (p. 47). Positioning occurs interactively and reflectively as a function of narratives employed in speaking and from a subjective history brought to each encounter.

Persons as speakers acquire beliefs about themselves which do not necessarily form a unified coherent whole. They shift from one to another way of thinking about themselves as the discourse shifts .... Each of these possible selves can be internally contradictory or contradictory with other possible selves located in different story lines .... The possibility of choice in a situation in which there are contradictory requirements provides people with the possibility of acting agentially .... [As we socially construct] the person as a unitary knowable identity, we tend to assume it is possible to have made a set of consistent choices located within only one discourse .... We struggle with the diversity of experience to produce a story of ourselves which is unitary and consistent. If we don’t others demand it of us.

(Davies & Harré, 1990, p. 59)

Similarly Hollway (1989), integrating psychoanalytic and Foucauldian thought, developed a feminist emancipatory theory utilising notions of consciousness raising, multiple subjectivities and discourse analysis. According to Hollway, people make a reasoned decision an investment in which discourses or position they will take up, however, this is not always conscious and people may be positioned in various discourses that are contradictory to each other at the one time. Bloom (1998), in a similar method to Hollway (1989), utilised the term nonunitary subjectivity to explore narratives in her research and to analyse the different subject positions of both herself and her participants. Bloom identified the multiple subject positions of participants as respondents, professors, feminists, managers, and her own multiple subject positions as researcher, student, and feminist. Whilst she acknowledged her own multiple subject positions and the conflicts and issues of power that ensued, the text is
written from the perspective of an author with a stable unified subjectivity. Bloom builds
upon the notions of Ferguson (1993) in combining both feminist interpretive and postmodern
practices. The feminist interpretation centralises subjectivity and gives voice or valorises the
experience of women, whilst the postmodern interpretation examines the subject as a
function of discourse.

Considering the literature on nonunitary subjectivities, there is a paucity of research or
literature written with the author positioned as having a mobile subjectivity. Hertz (1997)
and Franklin (1997) advocated for multiple voicing or polyvocality, however, this is in
reference to research participants rather than the researcher or author. Lincoln (1997)
asserted “if we are not just a single person, but rather a multitude of possibilities … as
ethnographers we could be about utilizing these multiple selves to create multiple texts”
(p. 42). Gergen and Gergen (2000) also advocated for expanding the potential of qualitative
methodology utilising polyvocality to give expression to the multiplicity of both participants
and the researcher.

There is a pervasive tendency for scholars … to presume coherence of self.
Informed by the Enlightenment conceptions of the rational and morally
informed mind, they place a premium on coherence, integration and clarity of
purpose. The ideal scholar should know where he or she stands … [and] may
lay claim, for example, to being a ‘Marxist’, a ‘masculinist’, or a ‘Gray
Panther’. Yet … the conception of the singular or unified self is both
intellectually and politically problematic.

(Gergen & Gergen, 2000, p. 1037)

Gergen (2001) asserted most people are seldom univocal but rather fundamentally
multiplicitous. Having a view derives from social processes or social positioning as opposed
to an interior origin. Polyvocality demonstrates a degree of similarity rather than repudiation
of all that differ. Rather than establishing an unbreachable gap between self and other, “the
revelation of one’s counter-capacities renders one ‘part of the other’. A space of
vulnerability is created which invites the other in as a collaborator as opposed to an
antagonist” (Gergen, 2001, p. 60). Othering and exclusionary practices within nursing are
overtly evident which mandates nurses commence thinking and participating in inclusionary
engagement (Canales, 2000).

Positioning myself as author with a nonunitary or mobile subjectivity allowed for my own
differing subjectivity, or subject positions to be adopted, rather than presenting the thesis as a
text which represented a unitary truth. The use of multiple perspectives helps to uncover
alternative interpretations that otherwise may have escaped consideration (Savage, 2000).
Further subject positions could have been explored, however, for purposes of clarity and, for
the appropriateness of addressing the research topic, the positions adopted have been
confined to those positions articulated within this chapter. The positions are not categorically
delineated but flow between, overlap, conflict and, at times, resonate with each other as
multiple discourses.

As a research strategy, positioning myself as having a mobile subjectivity interrupts the
smooth claim to truth of the author whilst simultaneously also acknowledging that the text is
still but an interpretation (a representation) with myself as author. The researcher ultimately
retains the power of redirection of the research (Gergen & Gergen, 2000; Reay, 1995).
Invoking myself as author with a nonunitary subjectivity also acknowledges my own
subjectivity which would otherwise “deny the subjective experience of the researcher as
woman” (Cotterill, 1992, p. 605). Finally, presenting the data from the positions of a mobile
subject permits the multiple voices of participants to be heard, valorises women’s experience
whilst simultaneously interrogating the representation of discourse within the context, and
seeking alternate discourses, positions, and sites of resistance. Richardson (2000) offered the
idea of a crystalline view as combining

symmetry and substance with an infinite variety of shapes, ... multidimensionalities and angles of approach .... [They] reflect externalities
and refract within themselves, creating different colors, patterns and arrays,
casting off in different directions. What we see depends upon our angle of
repose ... it provides us with a deepened, complex, thoroughly partial
understanding of the topic. Paradoxically we know more and doubt what we
know. (p. 934)

Reinharz (1997) advocated that we have many selves that we bring to the field of research.
They include the research-based selves, the brought selves (historically, socially, and
personally created), and the situationally-based selves, each of which have a distinct voice.
Furthermore, in order to be reflexive we need to interrogate our multiple selves regarding the
contradictions and paradoxes that form our lives.

Summary
This chapter has mapped the major theoretical perspectives that inform this thesis, those
being critical social science, feminism, and postmodernism. Whilst the three paradigms and
the important concepts from each were initially discussed separately, their borders were also
problematised. Rather than depict concrete categories, the postmodern notions of
complexity, continuity yet discontinuity, fluidity, overlap, and the analogy of the refractory
and reflective crystalline view was utilised. Hall (1999) stated there is value in
postmodernism in reflecting the complexity of realities in marginalisation that enhances
rather than constrains social change. Postmodern insights acknowledge heterogeneity and
diversity whilst illuminating complexities about power, language, desire, and experience.
The important concepts of subjectivities and agency were also discussed, together with the tension of these notions within the paradigms.

It was noted that when an affirmative postmodern view is taken, the three perspectives are congruent in their teleological and critical intentions to improve social existence by interrogating and overturning everyday understandings and social arrangements, so that people and women can relate and act in fuller more satisfying ways (Fay, 1987). Postmodern views that examine complex issues of power relations and work against modernistic assumptions of humanism, identity, and subjectivity complement critical insights, however, the political implications for women and the intent of these views can be questioned. Feminist scholars, however, have noted that the disparities and contradictions raised in such explorations can be prized and a source of affinity and connection, resulting in solidarity in politics and shared conversations in epistemology (Haraway 1991). Whilst the question of subjectivity construction and agency is raised particularly within Foucauldian notions of postmodernism, the benefits of the ongoing constitution of subjectivity have been noted. Agency, not determinism, lies in the ongoing constitution of the subject (Butler, 1992). The later work of Foucault (1997) also advocated that freedom lay in our ability to think and reflect upon problems. As such, it is concluded that we are thinking individuals whose freedom lies in our ability to reflect, critique, think, and imagine.

Finally, the notion of mobile or nonunitary subjectivity (Ferguson, 1993; Bloom 1998) was examined and how this notion was utilised within this thesis as a strategy to highlight the issue of authorial representation and to disrupt the notion of a single unitary truth. The difficulty of contesting the embedded and expected modernistic view of a unitary cohesive self was identified and the advantages of revealing one’s counter-capacities to reduce othering were discussed. The political struggle is to see from many perspectives at once because each reveals both dominations and possibilities unimaginable from other vantage points (Haraway, 1990). Multiple positioning also enabled the voices of participants to be centralised and valorised whilst simultaneously alternate positions enabled discourses, power relations, and practices within which the subjects spoke and acted to be called into question without denying the responsibility for authorship. The manner in which these theoretical positions influenced my notion of ethnography and the details of the method of the study are described in the following chapter.
Chapter Seven

The ethnographic method—

*The art of listening*
Introducing the ethnographic method—The art of listening

Methods of inquiry that grow out of philosophy, the arts, and the humanities, rely heavily on the artistic talent, the creativity, and the skill of performance of the inquirer. The evolving methods require their own specification of the ‘rules of conduct’ ... but these [themselves] are part of the artistic endeavor—that process that creates something refined out of the rough, the raw, the undeveloped. If we build on the fundamental principle of creative potential ... then we can abandon allegiance to method for method’s sake. Instead as new methodologic approaches are explored, developed and implemented, we can ask questions that pertain to the art of the inquiry, such as “what potential is emerging here that would not exist otherwise?”

(Chinn, 1994b p. vi)

The ethnographic method utilised within this thesis is outlined in this chapter and builds upon, and is informed by, the theoretical paradigms described in chapter six. Whilst the theoretical utility of ethnography has been debated (Clough, 1994; Denzin, 1997; Hammersley, 1992), the view adhered to within this study is consistent with Masemann (1982) whereby “ethnography refers to studies which use a basically anthropological, qualitative, participant observer methodology, but which rely for their theoretical formulation on a body of theory” (p. 1). As such, the view taken within this research is that ethnography is a method, but that any method, technique or way of gathering evidence must be consistent and inextricably linked to the theory it is informed by (Harding, 1987). Utilising the strategy of positioning myself as an author with a nonunitary or mobile subjectivity critical, feminist and postmodern notions are fluidly combined or integrated in smooth roving movement within this ethnography. Unlike the initial explication in chapter six, I do not attempt to markedly delineate the boundaries of each paradigm, but rove or move between the spaces contesting and questioning the borders. The notion of ethnography is initially discussed in this chapter, followed by a detailed elaboration of how the research was conducted. A theory of the social is also a theory of writing (Clough, 1994). Denzin (1997) asserted “theory, writing and ethnography are inseparable material practices. Together they create the conditions that locate the social inside the text” (p. xii).

Ethnography—Mapping the music

In order to grasp, map, and give voice to the multiple discourses and practices that shaped the context of nurses managing and being managed by nurses, an ethnographic approach to this research was selected. Ethnography does not represent a clear and coherent prescribed methodology, but rather it indicates a general research orientation and implies the charting of quite extensive sections of local societies or groups (Alvesson & Sköldberg, 2000, p. 46). An
ethnographic approach allowed for me to extensively enter the lived world of the nurses and
their culture to observe, talk, record, and be with nurses as I also became part of the research
process. Ethnography is both a method, that being fieldwork and a written representation of
its subject, that being culture or selected aspects of a culture (Brewer, 1994; Hammersley &
Atkinson, 1996; Van Maanen, 1988). De Laine (1997) denoted a very simple description of
the use of the term culture within ethnography as “a system of knowledge used by human
beings to interpret experience and generate behaviour” (p. 104). The concept or term culture,
however, has numerous interpretations and has in organisational literature often been utilised
in a static instrumental manner denoting something an organisation has or as a tool that
management can utilise (Hewison & Wildman, 1996). The view of culture utilised within
this study is that it is not a static object of analysis, but a multiplicity of negotiated realities
within historically contextualised and contested communicative processes. Like gender it is a
perspectival social construction where the struggle itself is as much of the culture and the
discursive production of competing discourses can be seen in written, spoken, or imaged
texts created through discursive acts (Allen, D., 1996). Furthermore, culture is “structured by
representations and by power … a network of representations—texts, images, talk, codes of
behaviour, and the narrative structures organising these—which shape every aspect of social
life” (Frow & Morris, 1993, p. viii).

Postmodern notions of culture question modernistic conceptions of culture as a deep, hidden,
coherent system of shared basic assumptions (Schein, 1985) and webs of meaning (Geertz,
1973; Smircich, 1983) shared among a group of individuals. Postmodern notions view
corporate culture as an interplay between reiteration and aesthetics with repeated artificial
and superficial logos, rituals, and stories constituting a simulated identity that seduces
organisational members to act by promising identity, affirmation, and glamour (Schultz,
1992). Furthermore, the contest of the management of meaning in a postmodern frame is a
contest of simulation of identity and meaning. Underlying patterns and fixed rules give way
to registering the changing combinations of cultural forms, fragments of meaning, the
specific and unexpected, the continuously new and unexpected ways of performing, and
accepting differences and discontinuity in organisational life (Schultz, 1992). Postmodern
analysis therefore stresses identity as superficial and constructed, and focuses on the
changing, fragmented, specific, and spontaneous interpretations by organisational members
rather than search for a deep unified truth embedded in a seemingly linear, progressive, and
illustrious history.

Traditionally, ethnography has been embedded in a regime of positivistic realism in that it
sets out to represent the empirical world that is and described what happened entrapping the
writer and reader into a nominal positivist world (Sultana, 1992). Ethnographic texts have
been like novels in that they tell stories, promise pleasure or at least new information to the reader and persuade readers they can step into a world and understand the subjectivities of the inhabitants. Furthermore they are seductive in that they portray the ethnographer as being able to produce truth from the experience of being there (Atkinson, 1990; Britzman, 2000; Tyler, 1987). However, an ethnography should be reflexive and identify the nature of the social interaction between the researcher and the researched (Hammersley & Atkinson, 1996; Pratt, 1986). It should also identify the theoretical assumptions and locate the context of the social processes, thereby recognising the limitations of the representations of reality (Hammersley, 1991, Woolgar, 1988). Ethnography is a complex intertextual practice and a lack of recognition of intertextuality occurs when ethnographers attempt objective reporting and fail to recognise their own constitutive elements and their own intertextuality (Tyler, 1987). Tyler asserted “readers must take the ethnographer’s word for that external reality or judge it by comparison with other texts of other realities whose externality is determined by yet other texts in an infinite or cyclical profusion of texts” (p. 91).

Authors of ethnographies also establish their authority by asserting special knowledge, factual writing styles and inlaying native voices (Atkinson, 1990; Clifford, 1986), and by seducing the reader with an account of the exotic (Woolgar, 1988). The structural-functionalist perspective of ethnography has failed to grasp the complexity and uncertainty of social life and to address notions of agency in reproduction and transformation (Angus, 1986). Richardson (2000) noted that “we have inherited some ethnographic rules that are arbitrary, narrow, exclusionary, distorting, and alienating” (p. 939). An assumption of ethnography is that by entering into close and relatively prolonged interaction with people in their everyday lives, ethnographers can better understand the beliefs, motivations, and behaviours of their subjects than they can by any other approach (Hammersley, 1992). Traditionally participant observation has implied simultaneous engaged participation and objective detachment, and that this impassive methodology produces documentary data that reflects the native’s own view (Clifford 1986; Tedlock, 2000; Tyler, 1987). More contemporary ethnographic approaches refute this imperial notion including the critical, feminist, and postmodern approaches of this research.

**Critical, feminist, postmodern ethnography—*Shall we dance?***

Critical, and to a greater extent, postmodern perspectives argue that a narrative or text is never complete, but that the ethnographic text is itself a construct open to deconstruction. Every effort of representation will always be incomplete and imperfect, however, this fluidity and movement permits further possibilities of interpretation rather than closure. Poststructuralist ethnography posits that the real of ethnography is an effect of the discourses
of the real, such that ethnography may construct or inscribe the materiality it attempts to represent. Being there does not guarantee access to truth, and reality is not out there waiting to be captured by language (Britzman, 2000).

Despite the limitations of representation, the distinct research method of ethnography, that of participant-observation in fieldwork privileges the body as a site of knowing, and destabilises mind/body, reason/emotion, objective/subjective dualisms (Conquergood, 1991). The embodied practice of being immersed in the field obliges the researcher to sensuously experience as well as intellectually experience the contextual contingencies that play upon participants. From a feminist perspective this was important, as well as the ability to share time and space with participants. As a nurse and a woman I understood the clinical field of nursing to be a highly complex environment, and therefore it was important to participate in the clinical field with nurses as closely as I could to gain the greatest understanding of the context. Given the horizontal violence and tension in respect to academic nurses (Glass, 1997; Sohier, 1994; Walker, 1997), I felt a closer relationship and greater acceptance of myself would ensue with participants by participating myself in the real world of nursing. Bodily rigours of shift work, the 4.00am shivers and shut down on night duty, sights and smells of necrotic flesh, the anguish of grieving relatives, and the complex interpersonal conflicts of numerous health professionals working in confined proximity I bodily experienced in the clinical field with nurses. Ethnography recognises that fieldwork is a form of communicative action on the basis of shared intersubjective time with others (Fabian, 1983) and that “interpersonal communication is grounded in sensual experience” (Trinh, 1989, p. 121). The communicative praxis of speaking and listening in conversation requires co-presence (Conquergood, 1991), and voicing differences of experience allows for women’s experience to be unsilenced (Brodkey, 1987).

Reflexivity, subjectivity of author, and participant author relationships are significant notions in feminist ethnography with contemporary research depicting the vulnerability, tensions, and complexities of the researcher/ethnographer. Williams (1993) noted the term reflexivity, whilst not used exclusively by feminists, has largely been shaped by feminists doing ethnography. Relations between the researcher and participants vary with the multiple and different subject positions adopted, and therefore the knowledge and understandings brought to the research by each individual (Bloom, 1998). Stacey (1988) identified the complexities of feminist ethnography including ethical issues, complex relations with participants, and potential betrayal and exploitation of participants. Within this current study, attempts were made to address power imbalances by spending time with nurse participants to gain an understanding of each as a person in their individual context, rather than just as a participant. In addition, issues that arose in the clinical context were clarified by participants.
and reflections made about the environment shared. Participants were encouraged to select
the site for their interview, to raise and discuss issues related to the interview, and to edit
their transcripts. Issues of power have traditionally concerned attempting equality with
participants and ensuring the researcher does not exploit the participants, sometimes at the
expense of failing to fully recognise the subjectivity and vulnerabilities of the researcher or
complexities involved in the varying relationships of researcher and participant. Issues such
as male participants and differing views in respect to feminism were discussed in chapter six.
Bloom (1998) contended “feminist ethnographers have been mostly silent on the thorny
issue of prejudice or misunderstandings within research relationships in deference to the
research participants—focusing instead on how the researcher has power to exploit the
respondents” (p. 52-53). This concern arises from the feminist desire to avoid asymmetrical
power relations in research, the commitment to ways of knowing that avoid subordination
and therefore to aim toward both the researcher and researched sharing the same plane
(Williams, 1993).

Consistent with the openly ideological feminist goal, the feminist conception brought to this
ethnography was “to correct both the invisibility and distortion of female experience”
(Lather, 1986b, p. 67) whilst simultaneously recognising the identity of both the researcher
and participants to comprise multiple and fluid subject positions or subjectivities.
Visweswaran (1994) argued that feminist ethnography should plot the silences and critique
anthropology’s scientific ethos by explicitly naming patriarchy. She further advocated that
experimental ethnography has not pushed the challenge to traditional anthropology far
enough and that personal pronouns such as I or we should replace the authoritarian paternal
voice.

Critical ethnography is an appropriation and reconstruction of conventional ethnography
with a concern to bring about human emancipation (Hammersley, 1992). It is driven with an
eMANIPULATORY principle that focuses on material and cultural practices that creates structures
of oppression and creates space for multiple voices to speak or be represented (Anderson,
1989; Denzin, 1997; Street, 1992). A critical ethnography is a cultural critique and
systematic protest against cultural hegemony. The ethnographer aims to identify, describe,
and to analyse the social construction of hegemonic practices and to “articulate
contradictions in the social system that would make those practices vulnerable” (Brodkey,
1987, p. 69). The political nature of critical ethnography as a set of related concepts and
research practices is performed with the purpose of producing “a particular articulation of
knowledge” for serving defined interests given that all knowledge forms are ideological
(Simon & Dippo, 1986, p. 196). This knowledge reveals the social practices as produced and
regulated forms of action and meaning that a particular group of people constitute as their
pattern of everyday life and should specify how such practices organise, regulate, and legitimate specific ways of being, communicating, and acting that is structurally sedimented in relations of power (Simon & Dippo, 1986). Sensitivity to the meanings and significance of other, self-reflection and ideology critique are important and researchers need to be “no less sensitive to his or her own subjectivity than to the meanings of other” (Huspek, 1994, p. 61). An inverted ethnography privileges silences by voicing the unsaid and is meditative and reflexive. If the researcher edits themselves into the text complete with their presuppositions and biases, enters into dialogue with the participants in an attempt at mutual understanding and gaining multiple insights, then an ethnography may become a vehicle to promote change by promoting a journey of silenced possibilities (Sultana, 1992).

A critical perspective, unlike traditional ethnography in organisations,

centers on the politics of interpretation through questioning how the researcher and the social actors construct acts of meaning. It exposes how power relations produce a sense of closure that result in accepting the status quo as natural and immutable … [it] is more than just an explicit representation of a way of life. Rather … [it] ask[s] “why that life as opposed to another?”

(Putman, Bantz, Deetz, Mumby, VanMaanen, 1993, p. 222)

The inclusion of poststructural elements within a critical ethnography can address some of the complexities and limitations of critical ethnography (Bruni, 1995; Manias & Street, 2001). These nurse researchers particularly noted the issue of empowerment, power dynamics in work groups, and the assumption that participants desire or want to change previously unquestioned practices. Postmodern ethnography concerns itself with borderlands, zones of difference, and busy intersections where many identities intersect and articulate with multiple others displacing the idea of a unified whole and rethinking identity and culture as constructed and relational instead of given and essential (Rosaldo, 1989). Poststructural ethnography is concerned with what structures meanings, practices and bodies, about why certain practices become intelligible, valorised or deemed as traditions, whilst other practices become discounted, impossible, or unimaginable.

The ethnographic life is not separable from the Self. Who we are and what we can be—what we can study, how we can write about that which we study—is tied to how a knowledge system disciplines itself and its members, its methods for claiming authority over both the subject matter and its members.

(Richardson, 2000, p. 939)

Ethnography is to “think the unthought in more complex ways, to trouble confidence in being able to ‘observe’ behaviour, … [and] should trace how power circulates and surprises, theorize how subjects spring from the discourses that incite them, and question the belief in representation”(Britzman, 2000, p. 38).
Whilst the explicit goal of an ethnography may be empowerment, dominant authorial assumptions frequently set the terms and create an other which in itself subordinates (Allen, D., 1996; McCormick & Roussy, 1997). Postmodern ethnographies therefore seek partial and local truths rather than grand narratives, they are contextualised and attempt to acknowledge the standpoint or perspective from which they originate. All ethnographic texts are systems or economies of truth which are inherently partial, committed, and incomplete (Clifford, 1986).

The intersections of critical ethnography with women-of-color womanisms/feminisms, critical race theory and poststructuralism lead us to embrace agendas of liberation that seek to uncover the multiple forms of oppression of women, while at the same time, rejecting metanarratives and claims to truth.

(Villenas, 2000, p. 79)

In a manner similar to the quandary Britzman (2000) articulated regarding the voice of participants within her research, I was attracted to critical ethnography from a desire to make space for voices that had previously been shut out of normative research. Britzman contended “for many who do ethnographic work … there is the political commitment to the right to speak, to represent oneself, however partially … [to] be committed to advocating subjugated knowledge” (p. 35). This resonates with hooks’ (1990) assertion that “moving from silence into speech is for the oppressed, the colonised, the exploited, and those who stand and struggle side by side, a gesture of defiance that heals, that makes new life and new growth possible” (p. 340). As a nurse and woman I was committed to the right and desire to give voice or make space from which nurses could speak, not withstanding that the account was inevitably an interpretation. Given this desire, however, I also acknowledged the issue of ventriloquy, of authors hiding or denying their own subjectivity in anonymous texts, and also of the complexities of relying on adult voices (Fine, 1992). Reflecting on her research experience, Fine noted that adult voices were “multiply-situated and their perspectives were stuffed with social contradictions” (1992, p. 217). Problematic issues of voice include the carving out of often unacknowledged pieces of narrative evidence that we select, edit, and deploy to border our arguments. Furthermore, it is often laced with perspectives of dominant classes and reproduced relatively uncontaminated by power relations where oppressed informants are neither free nor uncontaminated by dominant perspectives (Fine, 1992).

Ferguson (1984) also noted this issue of organisational discourse, arguing it contributed to sexual discrimination and the construction of gendered selves. She asserted public discourse, even when spoken by women, was not the language of women. Purkis (1994, p. 17) advocated for field research and a critical stance with the assertion that “all too frequently, nurse researchers take an unnecessarily naïve position with regard to accounts from research participants” and tend to fix their accounts so as to provide an account. In respect to this
problem of representation, Spivak and Gunew (1990) suggested working with an awareness of the problem rather than denying it in attempting to represent authentic voices as the problem might otherwise be compounded. My perspective and subject position therefore within this research roams from the desire to give voice to marginalised or silenced voices, particularly those of women (a feminist and critical perspective), to rethinking my notions of voice and agency and tracing and interrogating the discourses, practices, and power relations that shape nurses subjectivity (a postmodern perspective). Fine (1998) suggested we work the hyphen, revealing far more about ourselves, and far more about the structuring of Othering. Eroding the fixedness of categories, we and they enter and play with the blurred boundaries that proliferate …. That researchers probe how we are in relation with the contexts we study and our informants, understanding that we are all multiple in those relations. (p. 135)

**Ethnographic intentions—Getting to know you**

As revealed above, this ethnography therefore sought to map and explore nurses’ embodied experiences of nursing management by focusing on the local knowledges and clinical practices constituting the discourses of nursing management within the specific cultural context of a critical care unit. The multiple discourses were explored and interrogated both with participants where they desired and to a deeper extent by myself from the roving position of a nonunitary subject. Discourses within this context included “practices, behaviours, objects, technologies and concepts, all of which shape and form the body” (Threadgold, 2000, p. 50). Discourses were examined to elicit how truth was defined and by whom, the assumptions, effects, contradictions, silences, and the social practices necessary for the existence of the discourses. Practices surrounding the discourses were mapped, including power relations and the reinscription of discourses by clinical practices. Simultaneously, marginal and subjugated discourses were identified and highlighted in the form of alternate or oppositional knowledges and practices. Rather than focus on the genealogical or historical aspects of discourse, the focus within this ethnography was particularly directed at how participants were inscribed by, subscribed to, reinscribed themselves, or resisted the various discourses, including the multiple and mobile subject positions they advocated and adopted. The complex inscription of participants’ subjectivity and multiple subject positions constituted by competing discourses of nurses’ experience was utilised as a method of ordering the data analysis. The identification of complex subjectivities and contradictory and alternate discourses aimed to subvert and contest the unitary, androcentric, dominant notions of nurses’ identity and subjectivity and to surface and valorise alternate more complex subjectivities together with the multiple and marginal discourses embedded in nurses’ experience.
The ethnographic methods of participant observation within the clinical environment and in-depth interviews were utilised to generate reflective field notes and interview transcripts of nurses’ experiences. As ethnography is the reproduction or rewriting of culture, this research interrogated specifically the management culture of nursing within a critical care unit, given that this culture was held to be fragmentary and in constant transition. Nurses’ experiences were represented from the multiple subject positions of participants in an attempt to give some primacy and centrality to participants’ voices, whilst simultaneously balancing that tension with an interrogation of the culture and multiple discourses from a critical, feminist, and postmodern view. By positioning myself as a mobile or nonunitary subject, I aimed to subvert the notion of depicting a real reality or a description of truth whilst simultaneously acknowledging myself as a twin construction inextricably enmeshed in the research, and yet as having what Geertz (1988, p. 115) referred to as the “burden of authorship”. With the intention of subverting linear and restraining forms of categories and representation local knowledges and clinical practices that constitute the multiple discourses and culture and that inscribe participant subjectivity and bodily experience were explored and interrogated. Rather than the traditional detached and objective position of researcher/ethnographer, I attempted to locate myself in the research to reflect the complexities and to recognise and draw attention to the interpretive and partial views depicted in text. By roaming freely around topics, the writer breaks “our sense of the externality of topics, developing our sense of how topic and self are twin constructed” (Richardson, 2000, p. 935). Alvesson and Karreman (2000) noted that even when researchers philosophically question the assumption that language is the medium for conveying meaning that represents reality, they still write up their research as if language was impartial.

The following section now focuses on particular details of the ethnographic method employed in this research, including the selection of the research site, gaining access to the site, the selection of research participants, the methods of data collection, including participant observation, reflective field notes and semi-structured in-depth interviews, and finally a discussion of the data analysis.

**The selection of site—Invitation to the dance**

As referred to above, the ICU where this ethnography was undertaken was selected by myself on the basis of a telephone call from a nurse requesting that she and staff from her unit be involved with a research study regarding attraction and attrition of critical care nurses (Ogle & Ferguson, 1996). At the time of the call, the study was completed. On reflection perhaps I was flattered with the request; however, I noted her strong desire to participate. As I had not had extensive involvement with this unit and I wished to be perceived as a
researcher, this also made the selection of this site attractive. In my current employment I am a course coordinator for critical care nursing and collaborate with numerous ICUs. It is in this role that I suspected I would foremost be known. I was concerned that in these units relations of perceived power would be difficult to dissipate and the ongoing relations with these units also made me cautious that staff may not feel comfortable to disclose, discuss, question, or voice alternate perspectives if they believed I represented both the current organisational and political arrangements rather than being a researcher. As a student I was keen to utilise the opportunity to throw off the mantle of course coordinator that I felt kept me locked in a certain role and perception and invoke another me, the clinical, the personal, the student, and the academic me that did and thought other things than course coordination.

I initially contemplated utilising two sites for gathering data as I was not held to only investigating the area of critical care. Multisite ethnographies have the advantage of disrupting for the ethnographer that reassuring sense of being there (Marcus, 1995). As the study progressed, I realised the enormity of the task ahead and desired to achieve a greater understanding of one unit and the individual nurse participants, rather than attempt to spread myself across several units. Utilising a critical care unit as the site correlated well with my past clinical and academic background in critical care nursing, however, my interest in nursing management extended to all areas of nursing. With considered reflection I also suspected that I may have had more difficulty in establishing mutual relationships in undertaking the study with nurses in a non critical care area if those nurses perceived a difference in status between critical care nurses and non critical care nurses. Disclosing that I coordinated a course may have cemented this gap, but to withhold would have been equally as futile.

My background in critical care nursing and health management ensured I had a good knowledge of the general language of nurse managers and critical care nurses, and some of the nuances of their practice. This was an advantage in communicating with nurses, as I understood the complex and often technical aspects of their work without burdening them to educate me. The disadvantage, however, was both their and my assumptions of my knowledge. I often assumed what would or had happened and why, and likewise they assumed I knew things I did not. Many nurses assumed at times that my interests would, or should, be purely scientific or technical.

**Gaining and maintaining access—Knock knock, who’s there?**

In order to gain access to the unit I desired, I completed the ethics applications and was approved by the ethics committees of both the hospital where the critical care unit was located, and the University where I was enrolled as a Ph.D. student (see Appendix One). The University ethics committee at first questioned the notion of shadowing participants, which
surprised me but was easily explained and then approved. As I was not a staff member of the hospital where I wished to conduct the research, it was required that I be sponsored by a senior staff member from within the hospital. I telephoned, emailed and met with numerous senior nursing staff members outlining the intentions of my study and was readily given advice and support. The sponsor was promptly organised, the application signed by the head of the nursing department and, despite the mountain of paperwork (20 copies each of approximately 45 pages), my ethics application was approved by the hospital ethics committee, subject to University approval. I was concerned in negotiating this access to the hospital of the potential bureaucratic processes, potential gatekeepers, and policed delineated boundaries (Hammersley & Atkinson, 1996), given that my study utilised a qualitative critical methodology and involved extensive onsite observation. I was relieved with the ease of the process, but noted several factors that I believe assisted. The senior nurses within the hospital openly advocated for the support of nursing research and I suspect the notion of seeking alternate views and practices was aligned with the notion of progress. Senior nursing staff were invited to participate which was consistent with and enabled me to gain a stratified sample of nurses from many levels of the nursing hierarchy. Excluding male nurses would have excluded key senior nurses from being able to participate and therefore may not have assisted in the process of gaining hospital access.

Maintaining and ensuring continued access including the extent of access was important, particularly in respect to being informed about different meeting occurrences, when and where they were held, as well as their perceived significance. I believed depth of access occurred when I was invited to attend meetings considered potentially volatile by nurse managers, to attend meetings that were called due to unusual incidents, and to accompany a staff member in her confidential performance interview. Access to unit policies and staff rosters was important to work out holidays, shift irregularities, and the whereabouts of the vanished participant who couldn’t be asked of without potentially disclosing her confidentiality. An ongoing requirement of both ethics committees to maintain ethical approval was that I submitted six monthly progress reports for the duration of the research.

The participants—Musical artists

Following ethical approval from both institutions, 11 nurses participated in the research (in addition to myself). Some participants were senior nurses who had heard of my research from my initial discussions and were keen to participate. Other nurses were clinically based and either read of my research from a plain language statement (see Appendix Two) which I placed in the communication book, or attended one of several informal short talks I gave in the critical care unit about my research. I attempted to talk of my research at various change of shift times so as to encompass as many nurses within the unit as possible. All participants
were given a verbal explanation, plus a plain language statement to read and keep regarding the process of the research, and I requested that they sign a consent form (see Appendix Three). The participants were informed that they were free to withdraw from the study at any time. A list of local counsellors was available in the event that any participant felt any emotional discomfort. Whilst several participants indicated they had seen counsellors at varying times in their nursing career, they did not indicate a requirement during the study. The specific criteria for participation was that all participants were division one registered nurses with the Victorian Nurses Board and their employment within the hospital was directly related to the critical care unit, either in a clinical or managerial position, or both.

Participants ranged in their positions from being clinical nurses with just over one year of critical care nursing experience and primarily bedside clinical responsibilities, to more senior nursing positions with predominantly administrative responsibilities. Clinical nurses encompassed bedside nurse clinicians and clinical nurse specialists, which were the positions of seven of the nurses who participated. Four participants were from the group of nursing positions within the nursing hierarchy that encompassed associate unit managers, unit managers, nursing supervisors, clinical directors, and directors of nursing. The exact positions of each of the senior nurses are not specified in order to safeguard the confidentiality of participants. Nine of the participants were female and two male.

In order to ensure confidentiality, I assigned pseudonyms for the participating nurses. With careful consideration, androgenous and some non-Anglo Saxon names were utilised in an attempt to not reinscribe notions of culture and gender onto the participants. As identified above, closer inspection however allows for gender to be identified with the use of she and he, as I wanted to ensure male voices were not represented as female. The intention and result is some blurring and questioning of identity of the participants rather than the authorial reinscription of dominant and binary notions of identity such as gender, race, and culture. In-depth details of each participant are not included in this study as I viewed it my responsibility, as researcher, to safeguard confidentiality of participants. The following section briefly introduces each of the 11 participants, including some succinct demographic and social details.

1. Latu was currently in her early 30s. She had been employed as a nurse for 10 years, the last 4 within the current unit. She held a Bachelor of Nursing, a Graduate Certificate in Critical Care and was currently completing a Masters qualification. Latu resigned from her position to work in another nursing position several weeks after the study commenced. She was keen to participate and so readily assisted in negotiating the time and commitment of her participation in the study.
2. Chris, a nurse in her early 30s, had been employed as a nurse for 14 years and had worked in critical care positions outside of Australia, including that of a nurse manager. She had been employed within the current unit for 18 months and had completed an Intensive Care Certificate and other specialist nursing courses.

3. Sam, a nurse in her mid 30s, had completed a Bachelor of Nursing as a mature age student and a Graduate Diploma in Critical Care. She was currently also undertaking a further graduate diploma in a related discipline. She had worked in the current unit for just under 2 years and had been employed as a registered nurse for a total of 7 years. Since completing her Bachelor of Nursing, she had initially been employed as a registered nurse. Sam was then employed in a non-nursing senior management capacity for several years but decided to return to nursing. She resigned from the unit during the later part of the study to assume a nursing position in another critical care unit.

4. Pat, a nurse in her early 40s, had been nursing for 23 years with the last 14 years spent within the current institution. She had worked in a nursing capacity outside of Australia and had held several management positions. She had also worked in non-nursing positions and had been employed in her current position for 2 years. Pat held both Bachelor and postgraduate qualifications in nursing, including critical care nursing. She was currently undertaking further health-related studies.

5. Leslie, a nurse also in her early 40s, had been employed in nursing for 24 years. She held both a Bachelor of Nursing and a Critical Care Certificate. She had been employed within the current unit for the past 12 years in her current position. Leslie applied for and was successful in gaining a nursing position in another critical care unit during the later part of this study, which she was to assume shortly after completion of the study.

6. Tuin had been employed as a nurse for 5 years and was in her early 30s. She completed a Bachelor of Arts prior to commencing nursing and had been employed in non-nursing positions. She had been working in her current position for 2.5 years, also the length of time she had been employed within the hospital. She had also completed a Graduate Diploma of Critical Care Nursing.

7. Val, a nurse who had completed his critical care course within the hospital, was in his early 30s and had been in his current position for 2.5 years. He had been employed within the health sector prior to commencing nursing and had been employed within the current institution for 13 years. During this time he completed a Certificate in Critical Care Nursing. He was currently also completing a diploma not related to nursing or health sciences.
8. Alex had been employed as a nurse for 9 years and being in her late 20s was one of the youngest participants. She had been employed at the current institution for the last 3.5 years and held both an honours qualification and a Graduate Diploma in Critical Care.

9. Ash was in her late 20s and also one of the youngest participants. She had been employed in nursing for just over 7 years with the last 2.5 years being employed in the current unit and position. She had worked in other non-nursing roles. She held a Bachelor of Nursing, a Graduate Diploma in Critical Care Nursing, and had worked as a nurse in other critical care units in Australia.

10. Naz was in her early 50s and had predominantly been employed in a variety of nursing positions for just over 30 years, including some critical care and management positions. She held a Masters qualification in nursing and had been employed at the current institution in her current position for 6 years.

11. Jo entered nursing as a mature age student and had been employed in health and non-health related areas prior to undertaking a Bachelor of Nursing. Now in his early 30s, he had been employed as a nurse in the current institution for 3.5 years, had completed a Diploma in Critical Care Nursing, and had been employed for the last 18 months in the current critical care unit.

In summary, there were 11 participants, all of which were registered nurses whose work was directly related to the critical care unit. All participants worked a minimum of four days or more per week, although this was not a specific requirement of the study. The age of participants ranged from their late twenties to early fifties, with the majority of participants ages (8 of the 11) falling between that of 29 and 36 years. The number of years of nursing experience varied considerably among participants from 3 years to 31 years. All of the participants had clinical nursing experience within a critical care unit. Four of the participants currently held positions that designated nursing management as part of their title. Two additional participants indicated holding previous management positions. The qualifications of the nurses were extensive, ranging from hospital based qualifications to bachelors, postgraduate, and masters qualifications in nursing, and qualifications in other disciplines. All participants had completed at least two tertiary qualifications. Many participants indicated they lived with partners. Of note is that only one participant discussed or disclosed that they had children.

Participants entered the research in a variety of ways. Two staff members had previous knowledge of myself and indicated that they therefore felt comfortable and keen to participate. This was an interesting point to reflect upon considering my desire to enter a field where I felt less known. Once these participants joined, the word of acceptance seemed
to spread and numerous other clinical nurses also requested to participate. I do not know, and
did not ask, if the nurse who initially telephoned participated.

Data collection methods—*Do you see what I see/hear?*
Primarily there were two methods of data collection, in addition to my own reflective field
notes. These were direct participant observation of participants in the their work environment
and semi-structured in-depth interviews. In order to accomplish this, I spent approximately
two days per week in the clinical field for 10 months. That is, I spent approximately 10
months following, observing, working with, talking with and interacting with participants in
their normal work routines, including clinical care of patients within the critical care unit,
handovers, meetings inside and outside of the critical care unit, and formal and informal
encounters with other staff.

The observation of a participant preceded their interview so as to understand the context of
the participant more fully and to be able to clarify, probe, and discuss situations in greater
detail. However, as many participants were in close proximity, frequently they were
observed simultaneously and in interaction. The first five months of being in the field were
dedicated solely to participant observation. Interviews did not commence until the sixth
month of field observation. By being in the field with nurses prior to conducting interviews,
it also enabled participants to observe and interact with me. I hoped this would contribute to
decreasing power imbalances in the relationship and that the interviews would become a
two way point of communication, rather than just an impersonal imposition of gathering data
from rather than generating data with participants. I expected nurses would feel more
comfortable to talk with someone they felt they had been given time to get to know and who
themselves had spent some time being with them in their environment. Chiu (2001)
advocated that building a trusting relationship was essential with participants, particularly if
discussing sensitive issues or challenging any preexisting attitudes.

Participant observation and reflective field notes—*Watching you watching me*
It was important to observe participants in their work environment so as to capture the
practices that informed their work and the context in which these practices occurred.
Interviews alone would not capture this information. The mode of discussion, the discourse,
is not always and exclusively verbal: issues and attitudes are expressed and contested in
dance, music, gesture, food, ritual artifact, symbolic action, as well as words (Conquergood,
1991). Purkis (1994) also advocated for observational accounts generated by the researcher
in the field to problematise, question, and strengthen subjective accounts of experience given
by participants. I located myself in the field for full shifts and part shifts, attempting to
shadow where possible my participants and the shifts they were working. I intentionally
covered night duty shifts, afternoon shifts and weekend shifts to as closely as possible immerse myself in the environment of participants. By attending and working night duty, not only did I gain some respect from participants who stated they assumed I would not do this as an academic, but I also experienced the disorientation that occurs in the small hours of the morning and the fatigue that accompanies the solitary drive home on empty roads at end of shift. The time spent with each participant varied according to their desire and availability. I requested and spent at least two shifts directly shadowing each participant, however, as the participants all worked in close proximity, I found frequently that many participants interwove my time in the clinical field.

On entering the field I attempted to assimilate myself as unobtrusively as I could into the environment. I attempted to dress similarly to the nurses and assumed I had perhaps accomplished this when visitors asked directions within the hospital. Of the various forms of participant observation depicted by Gold (1958) and also Junker (1960), that is complete participant, participant as observer, observer as participant, and complete observer, the position I attempted to adopt was that of being between observer as participant and participant as observer. That is, I attempted to both simultaneously observe and participate with nurses in their work culture. Hammersley and Atkinson (1996) noted that these two categories are hard to delineate and I question if this is indeed even desirable as I found I adopted multiple positions which varied both with and between participants. Turnock and Gibson (2001) suggested summarising the role of the researcher rather than attempting to categorise it.

Mostly I was observer particularly in respect to nurses with administrative roles, however, I was often asked my opinion, which I freely gave. I requested and was allowed to follow nurse managers in all their routine and non-routine activities, frequently being invited to join in conversations. Nurse managers sought permission in advance for me to attend with them such activities as Board meetings and health and safety meetings. By way of introduction and explanation regarding meetings, participants were integral to my acceptability and therefore ability to access and shadow them into these aspects of their work. In more formal encounters, as I frequently had no knowledge of the content or agenda of prior meetings, I primarily observed. In respect to clinicians, I attempted to assist with clinical duties. I frequently found myself assisting with such things as the lifting and washing of patients, turning off alarms, holding the patient’s hand to prevent removal of the endotracheal tube, and generally the close bedside watching of intubated patients. I was surprised that I predominantly adopted the role of observer. On reflection I realised that I had over-estimated my ability to assimilate to a unit I had never previously worked in and the complexity of these nurses’ skills, whilst also attempting to undertake a research role. Rather than
attempting to fully assimilate into the practice domain I focused upon observing the participants, however, I was disappointed and reflected that my agenda for fieldwork also involved my respect and enjoyment of the practice of nursing.

The multiple roles of combining researcher and nurse in conducting fieldwork are complex (Allen, 2004; Beale & Wilkes, 2001; Cash, 1998; Chiu, 2001; Gerrish, 1997). Cash described in her research the different positioning she found herself in, utilising the framework of insider and outsider. Likewise I found my positionality as being a journey between various worlds, being both the insider and the outsider at once, and yet separately. My position varied from day to day, and between and with participants. I never felt a complete insider although I did develop close relations with some participants and wondered if many nurses felt like they were insiders. Similar to Allen’s (2004) description of identity work in her ethnography, I also found myself dressing, recounting stories, and participating in mundane aspects of work in order accomplish rapport and to appease my own sense of being an outsider and initial discomfort with the research role. On most days I fluctuated from feeling a sense of belonging to a sense of isolation, which depended upon the position of myself at the time, the participants and other staff, and activities that interacted in our encounters.

Nurses indicated some uncertainty that bordered on discomfort initially when being observed, despite my attempts to create a relaxed relationship. They wanted to know what I wanted them to do, which reminded me of the nursing tradition that defined and prided itself by doing (Hiraki, 1992; Walker, 1997). I felt they would have been happier if I had instructed them to perform specific tasks rather than to continue their usual functions. On several occasions I felt my clinical status or right to be there was tested, however, I also acknowledge, similarly to Gerrish (1997), my own anxiety in wishing to appear credible as a nurse. On one occasion when left alone with a highly unstable patient, I inwardly prayed that the patient didn’t do anything untoward. In all probability I would have handled the situation and plenty of help was near at hand, however, I felt my clinical capabilities were somewhat being tested. I was aware also that my presence altered the interactions in the clinical field. A nurse manager rather bluntly, in front of me, inquired from another nurse manager whom I was shadowing as a participant in respect to which university I was affiliated. I guessed the remainder of the conversation was tailored to my presence and felt at that point both an outsider, rather objectified and, to adopt a term from Gerrish (1997), a marginalised native. This contrasted starkly, however, with the keen efforts made by nurse managers to accommodate and participate in the research, including their voluntary and invaluable actions of introduction and explanation that privileged me extensive access.
In observing participants I analysed practices and forms of knowledge that constituted interactions (Street, 1992). Interactions frequently occurred in the unofficial domains such as the tea room, between patient cubicles, and in motion in the corridors. These interactions I considered as important as the more formal interactions in meetings, handover, and interviews. My observations were recorded in reflective field notes, which I wrote both at the time of observation and often between observations as I thought back and reflected on what I had observed. Reflexive thought is important data in ethnography that aims to question reality and the construction of truth (Lee, 2000). My reflective field notes contained vast descriptions, personal reflections and thoughts I had, both within and outside of the field. So as not to create a situation of participants feeling as though their every move and gesture was being intimitely recorded, I attempted to keep my note taking to be unobtrusive without disguising the fact that I was taking notes. I frequently utilised the tearoom within the critical care unit as a site of recording my observations and of jotting notes between meetings. I did, however, also directly take notes in the field, as well as reflect and further add to my notes hours after being in the clinical field.

Similarly to Gerrish (1997), the problem of maintaining anonymity and confidentiality for participants within the field I found difficult. Whilst I shadowed and accompanied a participant, I was concerned other nurses may verify that this person was participating in my research. In order to safeguard participants, I mixed my time of generally observing and being in the clinical field with direct shadowing. I also sometimes spent half shifts with nurses and then moved about to meetings, the tearoom, out to the wider hospital, or to other participants. My length of time in the field enabled me to mix my activities and also to observe participants at times I had not formally planned as nurses interconnected and interacted within the critical care unit and hospital.

**In-depth interviews—I don’t want fancy conversation, I just want someone that I can talk to …**

Due to issues of horizontal violence in nursing and the power dynamics that can occur in groups (Whelahan, 1995), I selected to conduct individual interviews with participants rather than group interviews. Nurses were free to discuss the study or engage in collective action with other nurses if they chose. By interacting with nurses on an individual basis I believed each nurse’s ability to articulate their own individual reality or multiple realities would be enhanced, rather than to conform to articulating only dominant discourses or social group expectations. I also viewed nurse participants as potentially vulnerable and wished to afford each the opportunity to freely voice, question, and reflect on their individual opinions.
Each of the 11 participants agreed to an interview, which were conducted at a time and place of convenience to them. I requested preference not to conduct interviews within the critical care environment as I had previously encountered electrical interference when audiotaping within a critical care unit. Five interviews were conducted within the hospital, three of which were with senior nurse managers. Five interviews were conducted with nurses within their home environment and one interview was conducted within an office at the campus of a local university. Each interview was initially expected to last approximately one and half hours. The length, however, of the interviews varied according to the conversation that ensued and the desire of the participant. Most interviews lasted close to two hours, with the shortest being 45 minutes and the longest being close to three hours.

The format of the interviews was informal and frequently included coffee and interruptions by such things as phones, other people, and pets. Interviews were semi-structured, in that I had a framework of open-ended interview questions that I asked each participant and briefly outlined to participants prior to the interview. The framework of open-ended interview questions is attached as Appendix Four. Interviews also allowed for me to clarify, probe, question, and discuss issues that arose in the clinical field. Participants readily discussed their views and experiences at length, which reflected what Street (1992) described as the strong oral culture of nursing.

Despite my intentions to ask similar questions in each interview, the subjectivity of each participant and the subject positions adopted by myself influenced each interview. Whilst, from a feminist perspective, I attempted to make the interviews relaxed and informal (Reinharz, 1992), on re-reading the transcripts, the amount and type of contribution I made to each interview varied considerably. In the first two interviews my questions were quite set, stilted, and formal as I navigated the process of the interview and entered into the lives of participants. In comparison, in the latter interviews I was more relaxed, curious for intricacies, and probing of the complexities. As the participants each had varying backgrounds and different nursing positions within the institution, I also found I related to each participant quite differently. In turn, each participant related different expectations of me. I found greater commonality with those nurses who were female and who had similar years of clinical experience to myself. This commonality, whilst creating a mutual sense of clinical understanding, also however cautioned me to attempt as best I could to work against the assumption that many of their views would be similar to that of mine.

The interviews proceeded as a type of ongoing conversation between myself and each participant where experiences were shared and explored in a reflexive manner as suggested by Hertz (1997). Participants were encouraged to recount anecdotes, to talk of comparative experiences outside of the unit, and frequently they digressed from questions to talk of
multiple topics and to discuss important issues not identified as specific research questions. Postmodern notions of the interview and the search for a deep and absolute truth can be aligned to a confessional (McHoul & Grace, 1993). Rather than attempt to seek for a single truth from participants by an invisible researcher (Fontana & Frey, 2000), I positioned myself as an active participant in the interviews and respected that each participant, including myself, held numerous subject positions. The choice of subject position or positions, however, was not something that could easily be commanded.

In interviews with nurses who held the most senior positions I felt compelled to adopt more of the subject position of the professional nurse researcher and was conscious of appearing informed, being organised, respecting their senior positions and experience, and of not getting in the way. Perhaps due to my nursing background and/or being a woman, without intention I found I adopted the position of what LoFland (as cited in Hammersley & Atkinson, 1996) described as the acceptable incompetent. This was a role of being formally pleasant whilst negating much authority and willingly conforming to others’ stated social rules of the situation. Likewise, the more senior nurses commenced their responses in the interviews with formal narration and explanations as each of us negotiated the knowledge, verbal and communication skills, and individual positioning of each other. This initial guarding gradually decreased as the interview progressed, however, it initially stifled the free flow of conversation, despite several days spent with each participant prior to the interview. Perhaps longer time may have diffused this guarding process which appeared as a careful and well-practiced response to their expectations of any formal inquiry. I suspect that senior nurses were perhaps further aware, conscious, or vigilant of negotiating power issues in comparison to nurse clinicians who generally were more casual in their response to the interview. The subject position I adopted (the formally pleasant and organised researcher), would also have influenced the interaction, as I found with clinicians I was unintentionally less formal.

Different subject positions were adopted by participants in respect to the issue of being knowledgeable about nursing management. Nurse clinicians tended to adopt (although with exception) a position that placed myself as the expert and themselves as fairly uninformed in respect to the theory or literature of nursing management, however, they positioned themselves as quite knowledgeable about their own and current local practices. The more senior nurses initially adopted a questioning and searching position regarding my knowledge base of management theory and literature, such that I felt some tension in not wanting to sound off as the informed academic but also did not want to appear uninformed. Either position was difficult, as to be too informed risked posing a threat to their comfort in discussion, and too little knowledge jeopardised the possibility of teasing out the
complexities and deeper questioning, discussion, and formulation of alternate views. I concurred with Britzman (2000) regarding the difficulty and tensions that arise in the clinical field in questioning the reality of representation and belief. Often alternate views could only be tentatively raised as topics and questions for discussion. In respect to the aspect of management practice, the more senior nurses adopted, to varying degrees, a position that they were the expert management practitioners. I was very pleased to be able to readily acknowledge their expertise and primacy in local knowledge, however, this also was influenced or tainted I felt at times by the perception of academics as lacking in clinical or practical acumen. I noted that this made the interview a complex process of negotiating realities, where I often struggled in questioning both the multiple realities of participants as well as those of my own.

To all participants I attempted to portray myself as a friendly nurse, a woman, and researcher who openly admired their skill and knowledge and was keen to elicit and discuss their experiences and views. Their perception however of myself as an academic, a researcher, a nurse, and woman was infused with their prior notions of myself and that of the multiple roles or positions of who I was. Furthermore, the interaction was marked as well by the subject positions I adopted in conducting the interviews. The social interaction of the interview was imbued with complex power relations (Bloom, 1998), influenced by both my subject positions and that of the participants.

Whilst each participant was aware that my research was informed by feminist principles, I did not assume that they themselves adhered to or desired feminist goals. Most participants conveyed an understanding that by participating they were displaying a personal and professional commitment to further nursing research. Many participants overtly stated they did not believe gender to be an issue in nursing. Given that the interviews were audio recorded, that I predominantly asked the questions and wrote up the results and that they were aware the research would be published, it would be naïve to expect participants not to acknowledge or recognise that as participants they themselves were vulnerable and the power relations ultimately unequal. In hindsight, when I read the interview transcripts, perhaps my subject positions did convey an extension of friendship more than I initially thought, however, I also believe as nurses they were extremely generous in being as little guarded as they were.

On completion of each interview the audiotape was transcribed and a copy of each participant’s interview transcript was sent to the individual participant. I asked each participant to verify its accuracy, check the transcript for personally identifying information, make changes if they had concerns with the material, and to comment if they desired on how they felt being involved in the interview. All 11 participants returned their transcripts with
very little prompting. One participant requested several sections of her transcript be removed that related to relations with a fellow nurse in the clinical field. Another participant identified aspects in the transcript that she thought could potentially identify her. Many participants noted with dismay how their verbal talk translated onto paper as if it reflected personally on their ability to communicate. Several participants commented that they enjoyed being able to talk about their experiences and to have someone interested in listening to them.

Data analysis—Shake it up baby

Data was analysed primarily by myself particularly in respect to the deep theoretical questioning, however, as analysis is an ongoing process participants were continually involved throughout the research in searching for and contesting the multiple experiences, realities, and discourses that arose. Participants were involved both in interviews in questioning assumptions and in seeking alternate views, and in the final editing and verifying of their interview transcripts. Whilst not directly recounting one participant’s thoughts to another, I frequently raised issues to participants in their interview that had been raised in prior interviews or in the clinical field to clarify and to seek new and differing interpretations. In previous nursing ethnographies (Manias, 1998, Walker, 1993; Wicks, 1995), deep analysis of data has been performed by the researcher, although with critical and feminist research there is a commitment to include the participants in the entire process where possible (Bunting & Campbell, 1994). A difficulty of deep theoretical interrogation by participants is confronting participants who frequently overtly espouse to value experience over theory with theories that agonise their experiences and beliefs (Britzman, 2000). The debatable issue of presuming participants are willing to be involved and effective as a group in theoretical questioning (Manias & Street, 2001) led me to individually involve participants in the early questioning of discourses and practices. Rather than assume all participants desired the same level of participation, I attempted to accommodate their involvement according to their desire, so that for some participants there was more theoretical questioning and debated discussion whilst other participants primarily shared rich descriptions of themselves, their perspectives, and their lived experiences.

Utilising a modified version of the steps outlined by Parker (1992), I sought to identify and analyse the discourses embedded in nurses’ experiences that shaped the cultural text of nurse management. I included both clinical practices and local knowledges, that is the reflective field notes and interview transcripts, as constituting “tissues of meaning as texts … [as] all the world when it has become a world understood by us and so given meaning by us, can be described as being textual”(Parker, 1992, p. 7). This is similar and consistent to the
Foucauldian notion of discourse that is inclusive of practices, behaviours, objects, and technologies (Threadgold, 2000).

Parker (1992) noted, similar to Potter and Wetherell (1987), that the process of discourse analysis is not a sequential method, and that it requires some level of intuitive feel and resonance with own experiences (Hollway, 1989). For this reason I found myself constantly re-reading my reflective field notes and listening closely to the interview audiotapes in order to gain a deep understanding of the data.

Parker (1992) recommended the texts be explored for connotations, allusions and implications, preferably with other people. The knowledges and practices were explored and interrogated both with participants, where they desired, and to a deeper extent by myself. These knowledges and practices, that is, discourses, were then examined to elicit how truth was defined, the assumptions, effects, contradictions, silences, and the social practices that supported the discourses. The social production of practices surrounding the discourses were mapped, including power relations and the values that justified the discourses and their transmission. Parker (1992) also advocated contrasting ways of speaking and discourses against each other. Simultaneously, marginal or subjugated discourses were identified and highlighted in the form of alternate or oppositional knowledges and practices.

Data was further analysed to focus on how participants were inscribed by, reinscribed themselves or resisted the dominant discourses, including the multiple and mobile subject positions they advocated and adopted. Davies and Harré’s (1990) notion of position within a discursively produced multiple selfhood was utilised in this aspect of data analysis. Participants’ multiple subject positions were identified which were the vantage points a person sees the world from “in terms of the particular images, metaphors, story lines and concepts which are made relevant within the particular discursive practice in which they are positioned” (Davies & Harré, 1990, p. 46).

These multiple subject positions constituted by competing discourses of nurses’ experience were utilised as a method of ordering the presentation of data. The subject positions identified were those that participants predominantly adopted throughout both the individual interviews and in my reflective notes from the clinical field. This notion of subject positions has been utilised previously, often in conjunction with discourse analysis in feminist research (Bloom, 1998; Hollway, 1989), and in nursing research (Fahy, 1997; Traynor, 1994). Consistent with these previous studies, most participants in this study adopted multiple subject positions and frequently contradicted themselves within and between various subject positions. As described by Davies and Harré (1990), “persons … shift from one to another way of thinking about themselves as the discourse shifts …. Each of these possible selves
can be internally contradictory or contradictory with other possible selves located in different story lines” (p. 59).

With nine major subject positions of the participants identified, the discourses that informed each subject position were then related and subjugated or marginalised discourses also noted together with their associated practices. The final process in the analysis of data was to analyse and include myself in respect to the subject positions that I adopted throughout the research process. With the participants’ subject positions already analysed and identified, I was shocked from this self-interrogation of how well I fitted within most of the subject positions.

By presenting the data from the multiple subject positions of participants, some primacy and centrality was given to participants’ voices and to women’s experience whilst simultaneously the discourses and practices that informed and reinscribed those positions and participant subjectivity were interrogated from a critical, postmodern, and feminist view. Alternate and marginal discourses, positions, practices, and sites of resistance were also identified. Finally, as author with a mobile subjectivity, the notion of depicting a real reality or a description of truth was subverted whilst also acknowledging my own subjectivity which would otherwise have “den[ied] the subjective experience of the researcher as woman” ( Cotterill, 1992, p. 605).

**Summary**

This chapter has outlined the ethnographic method utilised within this study. Drawing on the theoretical explication in chapter six, it outlined the critical, feminist, and postmodern notions of ethnography within the study which were combined by positioning myself as an author with a nonunitary or mobile subjectivity. An ethnographic approach allowed me to extensively enter the lived world of the nurses and their culture to observe, talk, record, and be with nurses as I also became part of the research process. The embodied practice of being immersed in the field obliges the researcher to sensuously experience, as well as intellectually experience, the contextual contingencies. From a feminist perspective, this was important, as well as the ability to share time and space with participants.

The selection of the site being a critical care unit within a large hospital was discussed together with the selection of 11 participants who were briefly introduced. Participant observation recorded in reflective field notes and in-depth semi-structured interviews were described as the methods for data collection. The interviews proceeded as a type of ongoing conversation between myself and each participant where experiences were shared and explored in a reflexive manner. The identity work of assuming a researcher role within the clinical setting, whilst simultaneously attempting to develop rapport with participants, was
both complex and difficult. Multiple and changing positions were adopted by myself in interactions with participants, including the acceptable incompetent and perceptions of being an insider and/or an outsider. This made the interview a complex process of negotiating realities, where I often struggled in questioning both the multiple realities of participants as well as those of my own.

The analysis of data, drawing on Parker’s (1992) notion of discourse analysis and Davies and Harré’s (1990) subject positions to elicit multiple discursive constructions of subjectivity, were also considered. The strategy of roving between subject positions to subvert a realist interpretation or a depiction of truth was discussed, whilst it also served as a method of locating myself as a twin construction within the research. The following chapter (chapter eight), presents and discusses the data from this study.
Chapter Eight

Data and discussion—

Nurses’ multiple com(positions) on the subject of management
Introducing the data—Nurses’ multiple compositions

This chapter specifically describes and analyses the experiences of the 11 nurses who participated in this study. The data comprises both interviews with the nurses and reflective field notes. It is organised with participant experiences grouped according to nine subject positions that I identified as adopted by the nurses during this study, and reflects the construction of both their subjectivity and personal identity. Performing this delineated categorisation was of concern to me, however, it was necessary to give some summary order to the data, to present the multiple views of participants, and to reflect the analysis of discourses and practices that shaped, subscribed, and reinscribed these subject positions. A discussion of the relationship of the current literature to the data is integrated and woven throughout the data and discussion in this chapter.

The nine subject positions of participants identified were the:

- junior novice—playing second fiddle
- detached unmotive individual—the syncopated clock
- pleaser—the joy bells
- exceptional and elite—the prima donna
- expert clinician—the virtuoso
- emotional human—resonating from the heart
- personal improver/coach—the maestro
- keeper of order and appearance—sounding the tone
- strategist—simply irresistible.

Subjugated discourses are included with each subject position where appropriate, however, the intent was not to create a distinct binary system but instead to display the multiplicity of perspectives and opinions, the practices and discourses that informed and reinscribed the subject positions and the effects and fluidity of individual subjectivity. Some positions are identified as being marginalised positions. For example, the subject position of junior novice comprised a large part of the data and is represented as a distinct subject position together with subjugated discourses. The subject position of the emotional individual comprised a smaller but still significant part of the data and therefore it also is represented as a distinct subject position. However, I believe this was a marginal position and its prominence may be attributed to the private and sensitive nature of the individual interviews. Subjugated discourses are therefore not included. Nurses rarely spoke from this position when at work in the clinical unit and tended to talk more from this position in their interviews. The subject positions are my interpretation and therefore further and alternate interpretations are both possible and likely. In order not to attempt to explain away situations and to create fixed meanings, contradictions and conflicts are frequently exposed and left in tension as
unanswered questions so as to reflect and highlight the complexity and to keep open the notion of multiple and further possible realities.

Analysis of the data is inclusive of my own fluid subjectivity and freely moves between critical, feminist, and postmodern perspectives. The critical exploration aims to subvert and disrupt the apparent naturalness of nursing relations in respect to management and to raise possibilities for alternate conceptions. Feminist insights aim to critique the inscription of gender in this predominantly female occupation, to interrogate the constructions of female identity, and to make space for nurses to speak of their embodied experiences. The postmodern perspective particularly subverts the notion of the unitary subject that is rational and transparent to itself and as the origin and basis of social relations (Lacau & Mouffe, 1985). By displacing this coherency and presumed free development of social relations, the reproductive processes which structure the self, prohibit self differentiation, and create a false consensus with others have been identified. The suppression of the individual as filled with competing needs and interests and as a subject in many discourses, positions others in pre-scripted relations to the person (Hollway, 1989). Congruent with the overall intention of this thesis, the use of multiple perspectives has elucidated alternative interpretations which might have escaped consideration in providing a unified version of reality (Savage, 2000).

**Shifting and fluid subject positions—Footloose**

Consistent with the theoretical framework of this thesis, subjectivity is viewed as partial, fluid, and nonunitary, such that participants freely moved between subject positions, frequently adopting numerous positions but also, as individuals, they were not constrained to be equally informed by every subject position. Participants frequently adopted conflicting subject positions. In their individual interviews, nurses sometimes identified and expressed concern that they held conflicting opinions. Other conflicts were evident only following analysis of the data. Data pertaining to one subject position also frequently displayed an overlap or consistency with other subject positions, thereby producing the webs of connection that ultimately supported, reinforced, and strengthened the preeminence and seeming naturalness of dominant views and discourses. This overlap has been intentionally exhibited, which necessitated at times quite lengthy direct descriptions and quotations of data. This simultaneously provided space for participants’ voices with little interpretation and provides possibility for the reader to interpret their view of the data (their story). As a participant researcher, my reflective field notes have been included by situating myself into subject positions as part of the data.
My general observations of the unit and the fast and fluid movement of subject positions I noted during one of my first shifts in the unit as evident in my entry from my reflective field notes. Some uncertainty with my own positionality is also apparent.

The unit is busy, noisy and cluttered. It is like a body factory. Vast numbers of beds are lined up in rows each containing a body surrounded by and tenuously attached to a vast assortment of machinery including the monitor which is the main activity center of each cubicle. The equipment is high tech but the old lino and dented walls tell tales of the age of the unit, which emanates contradictory messages of state of the art, yet public care. Tuin told me about the lady who she was caring for who had suffered major trauma including a serious degloving injury. “She incurred a head injury getting out of a stationary taxi”. Her tone was both cynical and mocking. I am confused. I know this is typical ICU talk as I have heard it before and it does not mean she does not care but from a researcher position it seems very stark. Tuin proceeded to the head of the bed and gently wiped the lady’s face. Leaning her own face close to the lady’s ear she carefully and slowly explained to the lady who she was and that she would be looking after her. Neither of us knew if this lady could hear. So why did Tuin adopt such a cynical position when she talked with me? I wonder what she expects of me or thinks I expect of her?

Each of the nine subject positions is now individually depicted. The order is not of consequence, with the exception of the first subject position which was by far the most predominant position adopted by participants.

The junior novice—Playing second fiddle
This subject position may be described as an inferior or subordinate position whereby the nurse adopted a position of being less knowledgeable, having limited experience, of being inferior to, and dependent upon, others. It was frequently assumed by participants despite their extraordinary knowledge of nursing, their extensive medical knowledge, their complex clinical expertise, and years of clinical nursing experience. It was not a position adopted by junior nurses as all participants were registered nurses with extensive experience and qualifications. Rather, it was a role of playing second fiddle or of being personally inferior to another. This subservient position was adopted very frequently by almost all participants and may be reflective of the fact that the participants were predominantly female and also nurses and had therefore previously been socialised into positions of subordination. This oppression and subordination of both women and nurses has been well documented in the literature (Ashley, 1980; Attridge, 1996; Chinn, 2000; Duffy, 1995; Glass, 1998; Hedin, 1987; Lee & Saeed, 2001; Roberts, 1983, 2000; Speedy, 2000; Willis, 1989). Many participants were aware that they adopted this position and talked about issues for themselves such as lack of confidence and issues of gender in nursing.
The extent of this subservience, however, I found remarkable. Having a perception of self that I was a fairly average female nurse, I then found myself reflecting on why I was overtly noticing this subservience.

I thought all critical care nurses were a bit more assertive than this and it is a shock to find that these nurses lack so much confidence. Today I walked into a room to find two nurses reading the charts in a corner of the room while the medical staff discussed the patient at the end of the bed on the ward round. When they left the nurses complained to each other that no notes were written and they had no idea of the plan of care. When I explained my astonishment to them that they were excluded they shrugged it off as being undesirable but quite normal. Further questioning of nurses compounded my concern that this was really not unusual and whilst no one really liked it, it was the way it always had been. My assumption regarding confidence appears to be ill founded and perhaps the behaviours I expected to find were peculiar to the critical care units I have worked in. Alternatively, perhaps I have changed since then. Am I really that different? Not sure.

During his interview, Ash talked about his ability to contribute to handover.

Oh there’s always a scrum there … everyone wanting to put their opinion in … probably my easy going [personality] sort of thing you know. I’d probably say something to make sure that they understood the situation from my perspective … it’s just me. I don’t make it a threatening thing or a complicated sort of thing. And of course there is always the odd rude person.

Ensuring information was uncomplicated and that communication could not be construed as threatening again confirmed the nurses’ subservient position. Ash, however, appeared to have adopted a slightly less subordinate position in positively describing both his contribution and his personality. The medical staff that I witnessed working in the critical care unit and on the unit rounds were all men. Not only were the former two participants nurses, they were also women. This double whammy of oppression has been documented by Glass (1998). Whilst this inferior and subservient position may be likened to what has been documented as the nurse-doctor game (Stein, 1967), it also transferred over to the relations between nurses and nurse managers.

One participant, identified as Chris, articulated this position of inferiority very clearly as she described how she felt in her performance interview with a nurse manager.

I said in the meeting with [the nurse manager] that I did feel intimidated by him but I also said it probably wasn’t entirely his fault but a lot of it is my background and upbringing. Sort of being very respectful of authority and … I suppose in a way putting authority up on a bit of a pedestal. And yes so I find it hard to sort of joke around with him and just have ordinary everyday conversation with him. Partly because I know he
is very busy so I don’t want to take up his time talking about things, which are mundane things, and he would just be polite and listen to. Yes so I find it just difficult to – yes just to be I guess normal and talk about everyday things with him.

The conversation of Chris reflects and was informed by the managerialist and patriarchal discourse that privileges management as a highly complex superior occupation, compared to her own activities or concerns which she described as mundane. She identified herself as not being able to be normal and therefore she owned the responsibility for the perceived self-deficit. That the manager would then politely tolerate her was commensurate with this.

When asked if this response was with one particular manager or all nurse managers Chris responded

I tend to be just a little bit that way with nurse managers … the ones that have sort of moved up through the ranks and become ACNs … I’m a lot more comfortable with them because I see them as much more on the same level with me. It is probably vestiges of being a student because … [as] a student you feel like you are always on show and being assessed … if you do anything slightly wrong then it gets noted. Yes, so I still feel like that sometimes. But on the other hand I feel I am a lot more trusted by them and that they’re not really there looking to see what I have or haven’t done. Yes, they probably don’t really care because they know my work now – whereas I still feel like they do sometimes. It is still the same thing very much with [other nurse managers] … I’m not about to sort of chat to them on an equal level … I think its just part of the facts of working life – I like … to be really good at what I do and I’ve often thought about maybe going for a rep. job or trying something completely different … but then I’d have [those] horrible frustrating months of feeling really uncomfortable again. Like I don’t know whether it’s worth the price. I could probably do those jobs and be very good at them but I guess I’m just not confident enough to sort of step out and do it.

The practice of educating critical care nurses through a postgraduate critical care nursing course reinscribed this position and contributed to ensuring that nurses’ confidence remained low. This surprised me again, as I assumed from my past experience as a critical care course student, clinical nurse, and educator that these courses fostered confidence through knowledge and skill development, as well as the personal and professional recognition of achievement.
When directly asked if her critical care course increased her confidence Chris replied

No not really, I felt a lot less confident … but I think that’s because you get totally analysed and I don’t think [this hospital] is the most encouraging place to be at for your course although I think it is a good place to do it. I think you come out being very competent … you are sort of taught that you need to stand on your own two feet and be assertive and if you don’t like something … that you go speak to the person in charge and actually address the problem and not just take it. I wouldn’t say as a student you are overly encouraged in your work. I think it is done in a very negative way … I really felt I wasn’t very good at all in my course. Yes, confidence did not get fostered … I have had mostly encouragement since I finished my course and yet my problem is sometimes I have a hard time believing it you know.

This was consistent with the literature regarding the reinforcement of inferiority and subservience within clinical environments and hospital training programs for nurses (Nelson, 2001b; Reverby, 1987). It has also been documented more recently to occur in undergraduate university programs, despite thoughts that it would empower nurses against this subjugation (Allen, 1990, 1996; Clare, 1993; Mozingo et al., 1995; Walker, K., 1994). It appeared, however, to also be a technology of subordination that occurred in postgraduate nurse education.

Chris asked me, as researcher, to attend her meeting and appraisal with the nurse manager. Following Chris’ meeting and appraisal, my reflections were somewhat distraught.

Poor Chris, her nervousness was so obvious. She sat in the manager’s office, her back to the door facing the manager directly. Her feet swung in circles under the chair and she fidgeted with her hands, at times sitting on them to almost stop them moving. She really had difficulty in getting out the words she wanted to say, however, having something written down seemed to help and she was determined, almost self-righteously, to say something. The manager, however, was quite cool, sat in his chair with his feet stretched out and I think, in his way, tried to support her to say what she wanted. When he turned around, however, and switched on the computer, bringing up documentation of her past appraisals and reports, I wondered what real effect her verbal comments of feedback to the manager really had when what she said was not in any way noted or documented.

In her interview, I questioned Chris why she had particularly asked me to attend.

I knew you were there to observe relations between management and grass-roots nurses so I thought you might appreciate the opportunity of just seeing a meeting where we discuss some of those issues in process – I don’t know if it gave me an added sense of … maybe it did boost my confidence a little bit … just having someone else there – yes – could validate what I was saying and all … I certainly wasn’t
intimidated by you or I think I would have stated exactly the same things in the same way if you had been there or not .... I think because I was getting feedback on myself I felt a bit more confident giving feedback on him. Wasn't just one-way, it was two-way ... and I had time to think through what I wanted to say which sort of gave me a bit of confidence going in – and actually having things written down.

The textualisation of knowledge, including who had access, who performed the documentation, and what was documented, became a mechanism for creating or constructing what appeared and may be taken as reality, but that also reflected and reinforced inherent power relations (Campbell, 1992). Chris’ comments to the manager were never documented and appeared as a token which enabled managers to state that staff were encouraged to give feedback on managers and to raise any issues they wished.

In her interview, Jo also spoke about her appraisal.

I was really scared about [my appraisal] like when I went to [my manager] at my instigation to get it done … and he sort of said, “How do you feel about it?” … and I said, “I am really scared about it you know.” He said, “Why is that?” I said, “Oh I don’t know I think that most things that will come up I'll probably already know about”. But you know you always worry there’s something that will come up that you sort of … don’t know about.

The practice of appraisals appeared to be a game where participants adopted certain positions. Managers and clinicians knew there was a power differential, however, the game was played without this being articulated. Denying clinicians’ awareness of the power imbalance however further reinforced nurses’ subservient position inclusive of the act of self-instigation of the appraisal and their inability to articulate the power imbalance. That they were scared became a further self-deficit. Participants fulfilled and enacted these roles reinforcing their own subject position in a self-referring cycle. The experience of staff appraisals has previously been documented to be one of mistrust by nurses who reported concern that they could be used as a weapon against them and managers could manipulate them to satisfy a grudge (Goble & Holloway, 1996). Nurse managers also felt expectations to fulfil their position of superiority, which is described later in this chapter. A peer review process created a sense that all staff and colleagues were involved in the appraisal process and that the assessment was not just by a direct nurse manager. This softened the other power relations inherent in the assessment that involved how the assessment took place, if it was verbal or documented, where it took place, and the relative position of individuals in the discussion. This requirement to tentatively balance or negotiate power relations so that it is not absolute but in tension, aligns with Foucault’s (1977) notion of power. The peer
appraisal processes, whilst allowing for colleague input, also was a mechanism that encouraged internal policing of nurses’ behaviours by other staff and enhanced individual self-surveillance.

Chris, who had worked in the unit for two and half years, further described her view of the appraisal and meeting with her manager.

I have had many meetings with [the manager] before and brought up things that I’d like to see changed but that’s probably the first time I’ve actually sat down and thought properly and actually written notes and then gone in and talked. I appreciated the chance to do that. Thought that was good. It was verbal [feedback]. I did wonder at the time how much of it he would remember because one of the things which was quite important to me I felt he sort of went “Hm, yes, yes” and moved on to the next one. Like the issue that was quite a disappointment to me was – I find it really difficult to work long morning shifts … you often actually don’t get out to lunch till 2.00-2.15, 2.30 sometimes … So my suggestion to him was that … perhaps the afternoon staff could come out straight away – have handover and then we could decide between ourselves who goes to the in-service and who doesn’t. Yes, but I don’t know how much of that he actually – yes, took on board.

New nurses were often unaware of the behaviour expected, and particularly those who had not completed a course. A routine meeting occurred between a nurse manager, an educator, a nurse who was new to the unit, and her preceptor, to evaluate the orientation of the new nurse. It was not only the new nurse who was expected to be subservient but I also slipped very easily into this role. My position as a researcher did not have to be a subservient position, but I realised on reflection that I too adopted this position.

I feel bad. This nurse was really upset. In the meeting when asked how she thought she was performing she replied that she thought she was doing okay. The educator then asked her how she had formed this opinion. The nurse replied that the relatives had been happy with what she had done and had thanked her many times. The educator then informed her that she had looked after this same patient for three days in a row so that she should know what was going on with the patient. She then instructed her that she did not seek sufficient assistance or communicate to others what she was doing—so she had a communication problem. Tears welled in the nurses’ eyes and she did her best to continue the conversation, which was basically informing her that she was not performing to expectations. I sat there dumbfounded and shocked at the brutality of the meeting and the educator whom I had expected to be a supportive person. I suspect she was making the point to the manager that all staff should undergo a critical care course and that new untrained staff were an issue for her. This appeared to be occurring at the expense of the individual nurse. The manager and preceptor said very little and nothing to support the new nurse. Their and my
presence as witnesses, however, made the situation a type of public humiliation. After the meeting, I raced around between the cubicles to find this nurse. She was not one of my participants but I wanted to see if she was all right and tell her that I thought what had happened was awful. But she had gone. Why didn’t I speak up at the time? I did agonise but felt immobilised that I would be told I did not know the details and my role as researcher would be questioned. My silence prevailed which gave my apparent assent.

During her interview, Latu described one of her first shifts in the unit. Latu commenced employment in the unit having completed a critical care course elsewhere.

I was there very slowly and taking my time … had to do a trachy change first time. [I] had to wait for medical staff [and] … I couldn’t really start because they had come in to do the trachy. [I] had to change the haemofilter and probably only once had I ever used a haemofilter. And the nurse in charge bowled in and said “That haemofilter was supposed to go on. It was quite clear at the 11 o’clock round it had to be on”. But this is what this person was like and I just felt like bursting into tears. And then I was told this was what her attitude was always like and that she had done the same thing before.

A similar situation was described by Jo.

One of the new staff members this year … It was the first really ill patient she’d looked after, and she thought she’d done a really good job … and this nurse had walked in to the cubicle and … she’d been quite passive aggressive during the whole handover situation. And then she saw [a charting mistake]. She said, “Oh I’m really sorry. Like would you like me – I’ll go and get it changed.” … “NO, DON’T BOTHER … DON’T BOTHER.” … You know, she had her back to her not her face, you know … standing sort of, you know, with her back towards this nurse … so sort of telling her to back off kind of thing. And she said, “Oh God, I just like crept out of there you know.”… And so she crept out and didn’t want to say anything else. Too scared, type of thing.

This subordinate position was reinscribed by unit practices that valued efficiency and precision with little regard to the circumstances of the individual. Routine surveillance of staff by more senior staff who were frequently not backward in pointing out what were deemed defects in ward routine, with the assumption that the nurse must be able to circumvent any possible deviation to the unit routine, assisted the reinscription of this subject position. The resultant effect was that individuals felt ineffective and inadequate.

The novice or subservient position was not specific to clinical nurses, but also to nurse managers. I attended a hospital executive meeting to observe senior nurse managers where I made the following note.
The twenty or so seats are arranged in a big circle around the room with tables in the front of the seats. Each nursing co-director of a directorate is seated alongside their respective medical co-director as in partnership. My understanding is that these senior nurses are very proud that nurses fill all these co-director positions. Reports for each directorate are given by the respective medical co-director, with the exception of one directorate where it is given by the nurse. The doctor has already left.

The inferior position of a nurse manager was also evident in Pat’s interview, where she elaborated on her feelings of uncertainty with her position.

I find it a big jump ... some others have worked with the executive a lot more ... but some of my limitations are about sort of understanding how – you don’t pick this up overnight – understanding the really big picture stuff, which is what I am going into. You know, looking at developing what services we are going to need in our whole – directorate. Being able to be lateral and have a helicopter view. To be able to pinpoint what you need and all that sort of stuff, which those people do all the time. That’s their expertise, they have that helicopter view and they are all coming up with policies and, you know, different strategies. Strategic planning would probably be an area where I don’t think it’s out of reach, but is something I am going to have to develop in.

The managerialist discourse of policy development and strategic planning prevailed to support management as a superior, highly complex and highly knowledgeable occupation, compared to what Pat perceived her current skills to be. Pat’s further views on management were evident in her description of the development of a new nurse manager. Her description equated new with novice and displayed her view that the practice of being tough as a manager was a positive sign of growth and confidence. Pat related

She was a little bit tentative when she started off but she has developed confidence and she’s taking a much tougher stand on issues, whereas when she first became a nurse manager she was, you know, ... it’s really difficult. Do I be friends with these people – or don’t I? When do I take the tough stand? Whereas she is very clear about her expectations and in a ward like that it is absolutely needed ... and so she has had the confidence to do that. So watching her do that I have seen an enormous jump in her development.

This was supported by the patriarchal discourse that equates management with what are deemed positive masculine traits of decisiveness, toughness, and lack of emotion. Pat commented that she was very aware of gender issues and talked about her concern of at times being treated like a little girl by men. However, her discussion regarding management was heavily informed by a patriarchal discourse. Pat was currently completing management studies, which I suspected may have included some issues regarding gender but most likely
further reinforced the patriarchal discourse. Other participants also discussed and grappled with issues of gender.

Leslie commented in her interview on how she viewed nursing as a process of selecting predominantly *girls* and how this contributed to the subordinate position of women in nursing and expectations of nurses’ behaviour.

It’s a bit of self-selection and that sort of nurturing ... [those] old fashioned girlie issues that were put with feminine people ... I don’t know why I [lasted] — tenacity it must be ... I thought it was just a recent thing that I had been labelled as difficult ... [however] I found this ward report from when I was a staff nurse and it seems that it is not a new problem at all. If you say to any female nurse “they’re a real boy nurse” we all know what we mean ... they’re messy, sloppy and they try to get away with charm. They rise up the ranks because of charm, not because of hard work or any great aptitude ...

For some reason women are harder on women. They expect different behaviours of men and of women ... so if they don’t conform to what they think they should be, they’re a lot harder. Whereas men are given a lot more latitude.

When I asked Leslie if she would therefore prefer a male boss, given her assertion that females were harder on females, she replied

In theory I would say that that would follow but it’s my experience that it doesn’t follow.

Leslie viewed herself as different to many nurses and attributed this difference to her upbringing.

[I had] a mother who was incredibly strong [and] that's now manifest in me and how I approach things. Whereas the nurse role model is a lot softer and I think often I’m not sure now whether mothers still do it, but you know women are supposed to be softer, gentler, nurturing, accepting, and the martyr role.

Leslie’s talk centered on the compliant *girlie* behaviours expected of females, their subordinate position, and the institutional privileging of males. It is interesting that Leslie’s experience showed male bosses to be just as hard on females as women bosses, yet she blamed women for being harder. Males in nursing may be socialised like females due to the gendered nature of the occupation, however, Leslie’s explanation of the institutional subordination of women as being a problem of women (who become bosses) also perpetuated the patriarchal notion that judges the behaviour of women more harshly than men. This harsh judgement of women has been reported in the literature (American College of Health Care Executives, 1996; Briles, 1994; Duerst-Lahti & Kelly 1995; Kirchmeyer & Bullin, 1997). Leslie’s own clinical experience refuted this notion.
Whilst this subordinate position was frequently assumed by most nurses, disciplinary actions were invoked upon those who appeared to step outside this position of playing second fiddle or of being subservient. During the time of the study, 10 of the 11 nurses who participated were required to reapply for their own or another position within the hospital. Whilst it was generally assumed that most would regain a position, it was common knowledge that one management position was being shed and nurses were also being moved into different areas. The process resulted from a hospital restructure and served as a mechanism or technique of control. The following reflection was made by Val regarding an incident that occurred shortly after he was appointed as a nurse manager. The reflection is lengthy to accommodate his description of how he learnt to change his behaviour, and his dilemma of whether this change was good. As he was awaiting news of his position this also may have influenced his reflection.

As you get more experience probably in your role and you understand the politics behind a lot of things ... that not everything is possible, you can accept it maybe a little bit more. Whether that’s a good thing for my role is something that maybe I need to constantly reflect on ... Am I not pushing hard enough to get these things through? ... Is that me getting burnt out? ... I got into a lot of trouble over an issue when I was first starting ... [I] did something on my own without informing various managers ... I was so passionate about this is something that I need to do for my staff ... and I was getting enormous pressure from my staff ... I was certainly relaying that on to my management group and above my immediate management group and sort of hitting a brick wall. My perception was that they weren’t listening, and in part they were certainly listening but their hands were tied. So I went off and just did something myself, and got my wrists slapped for it in no uncertain terms ... Two years down the track would I do the same thing? ... I maybe have become more comfortable with that you can’t just do everything. ... If I didn’t jump in I mightn’t have satisfied my staff ... Have I taken a more managerial approach ... and I’m not looking after my core group? But my role ... it’s obviously broader than that ... I’ve got to sort of be in line with hospital processes as well and be that meat in the sandwich. Now ... I wouldn’t do it as quickly as I did then ... [I].might go about it in a different way ... The main issue came back that I did it deliberately knowing that I shouldn’t [have] ... Nursing management were absolutely livid, and hospital senior management were very concerned ... it went to the Executive ... And then I got a phone call from the C.E.O. at home one evening ... I’d only [just] been appointed ... So it was a pretty big thing.

Val further elaborated on what he termed his lesson in process and how he would now alter his approach to such a situation. He indicated that acting dumb was acceptable. To
knowingly perform an unauthorised act was not. This rule of process was more important than the action initiated which was never terminated.

It continues to be a very successful thing. Now two years down the track they are … asking for my advice which is quite ironic in itself. So if there was anything in it, it was a lesson for me about processes … I felt [they] went overboard in regard to the response. I was naïve at the time … If I hadn’t told anybody about it … [or] said, “Oh well just something the staff decided to do one day”, it could have been a very different story. So ‘deceitful’ was the word that was floated about to me. Would I now go over and naïvely say, “Oh this is what I’ve done?” … I probably might just go over and say, “Oh look, by the way, I’ve done this, I think it’s a really great idea” and just act dumb. [An ADON] who strongly objected to my processes and said I really needed to be disciplined on this … [phoned] me two weeks [after] to actually ask for [assistance from it] … It really smacked of sort of double standards or something … It has taken me a long time to get on to a relationship that’s okay with that person.

Previous literature has documented nurse managers to experience lack of organisational support (Pederson, 1993; Persson & Thylefors, 1999), however this has not included lack of support and poor interpersonal relations with other nurse managers. Feelings of inadequacy, accountability without authority, and stress as a result of being torn between staff and upper management in general, without the support of either group, has been documented (Jennings, 1990; Pederson, 1993; Persson & Thylefors, 1999). The quandary of nurse managers to change their behaviour to be more subservient and act dumb has not been documented.

This subject position was also reinforced by the notion that nurses were not intellectually bright or intelligent individuals. Within a managerialist discourse, managers are aligned with a superior and elite status (Onsman, 2002; Rost, 1994) and higher intelligence is described as a common trait among leaders (Bernhard & Walsh, 1995; Marriner Tomey, 2004). For nurses, despite a now high average entry score to commence university education (Ogle, Bethune, Nugent, Walker & Kaplonyi, 2003), their image is basically that of not being well educated, knowledgeable, or scholarly (Austin et al., 1985; Campbell-Heider et al., 1994; Donley & Flaherty, 1990; Roberts, 1983). Frequently, in this study, nurses referred to other nurses as being idiots, usually in relation to the lack of progress made by nursing as a profession. It was also very evident in the discourse of a nurse manager as described by Naz.

We are not getting the best and the brightest any more because of the sociological changes, the options for women for one … And to be honest I wouldn’t have been a nurse if I had been born 20 or 30 years later … I know exactly what kind of a student I was … how I ranked in my class and everything else … We did get the best and the brightest. We might have pouted it out of them because they had to conform to the
hierarchy, but I think they were still very intelligent people. We are getting a lot of very bright people who are committed but the mass, the middle of the bell curve, has shifted a bit. I don’t think it is quite at the level that it would have been 20 or 30 years ago in terms of intellectual capability.

**Marginalised and subjugated discourses: Equality and team relationships—**

*We are family, I’ve got all my sisters with me*

Marginalised and subjugated discourses were also evident to those patriarchal and managerialist discourses that supported and informed the subject position of being inferior or subordinate. Subjugated discourses were most evident in participants’ individual interviews when they were reflecting on issues. Marginalised discourses were of equality, of team relationships, and of valuing this over superior-inferior or hierarchical relationships. Skills of management were not privileged over those of a clinician, but instead were viewed as different skills. Viewing management as superfluous was a further alternate perspective.

Tuin explained her view that a manager needs to be just as much one of the team as all other nurses, and that they can belong or be owned by the team rather than *own* the team.

People will work better as a team if they see you as part of their team. When you become a manager you are not really part of anybody’s team any more and you don’t belong to the girls on the floor. You don’t belong to the nursing management hierarchy because you are just the plebe there managing the nurses. So you are on your own in that sense. I think you get more support from the clinical team if you are there doing it and they are working next to you. I think it’s crazy to have somebody with so many clinical skills sitting in an office and … the team jells better if each member of that team has got a specific job working towards keeping the team together.

As a nurse manager, Naz talked about resistance from nurses to other nurses who take up management positions and her view of management as not being better than nursing but being a role for nurses.

Thinking about nurses as being in a position to run hospitals is pretty remarkable. [A nurse CEO] said that the most difficulty and opposition [she experienced] had been from her own nursing board … to take on [such roles] … That’s what nursing should be doing but I guess to me it’s not that you’re going beyond nursing or you’re better than … it’s that you’re using your knowledge and skills which are very closely tied to the core business of the hospital, which is delivering care to patients.

The importance of a team was further supported by Naz who described, as a nurse manager, occasions where she interacted and joked with other nurses as equals. She however still
referred to ownership of meetings. She also clearly refuted some male leadership styles she had experienced.

I think it's great, you know. It doesn't worry me a bit, and so I love that sort of working relationship. Sometimes in my meetings you wouldn't know who was [more senior] sitting around the table. None of that matters to me ... I’m quite comfortable with this sort of incremental type of oriented way of doing things ... and I think it's because it's me ... it suits me ... I'm not sort of a trumpet person. So you need groups that have people with different sorts of roles ... and as long as my boss tolerates that and I don't get any messages that I need to be more like him ... we are quite a good balance.

Leslie also related her desire for equality in relationships, however she described what she felt was inequality in the relationships between nursing management and clinical nurses.

As I've become older I have realised how much nurses in management positions want to maintain their power base and how easily they feel threatened. I certainly remember as a junior nurse ... the power structure then was very hierarchical and very obvious and the rules—their rules—were there to be maintained. Whereas now there's a façade of a more flexible caring environment and we are allowed to call each other by our Christian names ... [But] even though the formal structures have gone, the rules are the same ... So it's still very much 'shut up and put up' but there's this sort of veneer of equality — I think they try and portray it as [that] ... but I don't believe that that has happened ... I really don't think the mentality of management has changed at all ... so now it's more dishonest. There is still that old mentality that you're a nurse and that you have to do as you are told.

Marginal discourses were also sometimes interjected among managerialist discourses. Pat predominantly articulated discourses that supported hierarchical relations, however, in her interview she articulated a view of how she acquired her managerial skills that she would have been unlikely to document on her formal curriculum vitae. Dominant discourses of management are that it is a highly skilled activity and that it is taught and learned from senior management mentors or via university qualifications.

My mother in particular was very much about developing relationships with all sorts of people ... She had a respect for all those people and — there is no doubt in my mind that I picked it up from her. I would have arguments with some charge nurses in the past about how you manage people. And some of them believed that their role was off the ward doing policy and planning ... whereas my then innate belief was that you needed to be credible ... to be on the ward ... to be working with the staff. You need to be there supporting them.
This marginal discourse of management acquisition would have been slightly more acceptable to dominant views on management had *mother* been replaced by *father*.

Not all nurses willingly adopted this subordinate position and expressed concern that relations with nurse managers were worse than the poor relations with doctors. Leslie explained her experience on a committee external to the hospital.

I was certainly the only full-time clinical person [on this committee] – the rest … were all DONs. Our director of nursing was on it and the power plays were just incredible. She wouldn't speak to me … she might sort of nod to acknowledge me but there was no conversation … and yet the thinking is that doctors are oppressing nurses …. And yet I found that in a forum full of doctors I was accepted, you know. If I said something, they listened, they were polite, they would ask my opinion. They would say "Good morning" to me or whatever … It was the nurses that were very down-putting and rude basically.

Leslie described her views of teamwork and the advantages of a small unit in having staff know and support each other. She also indicated that the demise of a team approach was going unheeded. Rather than view managers as having a superior intellect, she referred to a manager as being naive and stupid. This discourse is absent within the literature and whilst some research has been conducted into the issue of social cohesion within critical care units (Bailey et al., 1980; Boyle et al., 1999), the size of the unit has not been viewed as a variable for change.

There is not nearly the team mentality that there used to be. Things have just disappeared over the years, which is very sad … we worked together, [it] was a team thing and we all got on well, but that's dissipated over the years – [The unit was smaller then] …. It's crazy for the ACN not to be on the ward round because a lot of people do need that back-up … a lot of people wouldn’t even admit it … They wouldn’t realise that they feel intimidated … I don’t think [the manager does] realise. Naive and stupid and if somebody told him he wouldn’t accept it.

Alex also described the importance of teamwork and of staff supporting each other against the demands often made upon them. Her difficulty in supporting staff she attributed to the large size of the unit and therefore inability to know the experiences of other nurses.

The doctors can really come in with sort of bull-doze tactics and say … “We want to move beds 9, 10, 11 and 12 and take in 4 really sick patients”. You’ve got to be strong enough in yourself and you’ve got to say, “Well with staff on today we just can’t do that”. … You’ve really got to earn the respect of your own staff by sticking up for them … because if … you don’t … people are soon going to work out that you’re just the “yes” person. You’ve always got to think of where the staff are at … [and try to]
support them … But it’s not always possible. You don’t know whether Mary is on her
4th shift and if Jim’s on his – 16th … but you sort of hope if you’ve been on a few days
as well you sort of pick up the vibes. And recently … the unit had a very busy week …
come the Friday everyone went out for a drink. That’s not something that’s done well.
It was like “Gee, everyone went out for a drink” … It was really unusual.

The discourse of economic efficiency with large sized units dominated over subjugated
concepts of staff support and interpersonal relations. Alex further described how she felt
interpersonal support is lost in a large unit and that the issue was not a priority. Increasing
the size of the unit also involved the use of more temporary staff, which compounded the
problem.

Above our nurse manager [they] are pushing for more and more beds … everybody
was saying we’re going to be saving more lives [but] … you can only push people so
far. We introduced the 11th bed a while ago and now they’ve introduced the 12th and
we were told it would only be for a limited amount of time. They’re not going to shut it.
So you’ve got people doing extra shifts, people doing double, agency people being
contracted … It’s not the same as giving you more staff, more experienced staff …
You need to have support and we don’t have it, but we keep doing it … You do get a
very high turnover of staff … so you do bring in inexperienced staff, and you can come
on to a shift where you are in charge one day and you can have 4-5 people that have
been in the unit for a handful of months, and you’re expected to not only work out their
status … you’re expected to support [them].

Prioritising interpersonal relations and support over some of the traditional management
functions was strongly advocated by Alex. Her emphasis that there should be preoccupation
with the unit, rather than just concern with the requirements of the organisation, indicates
some resistance to the hospital’s ownership of the manager’s attention and time.

Unfortunately [interpersonal support] is not done enough because of time constraints.
[The manager]’s at meetings 80% of the days … I’m sure he doesn’t need to be at
most of them … some people might like going away … but they take up such a huge
amount of time. To think that you can manage people and people will be able to
approach you, and to deal with the ins and outs of everybody … We’ve almost got it
recognised that we are such specialised areas now … and although we’d all like to
think that we all function as one happy family we can’t … We’ve got to become a bit
more preoccupied with ourselves so to speak and stop flying off to all these things that
concern the hospital as a whole.

As well as the issue of time and lack of priority given to interpersonal relations within the
unit, Alex discussed her concern with the focus of the manager role and the difficult context
within which the manager functions. She predominantly articulated what she believed others thought, however, her depth of detail raises questions regarding her position and may indicate some movement between positions. Dominant discourses espouse that a good leader has influence with little reference to the constraints of the context and that all staff can be integrated to harmoniously follow a leader.

They see [the manager] as far removed from the patients … [and] that we’ve got a manager who’s never there, has no idea what’s going on, yet they make all these decisions that we have to go by … because then you lose the respect …. It’s a very hard thing … to go from working at the bedside to sitting in an office and managing things that you have no experience of whatsoever. I think [the manager]’s doing a great job under the circumstances, but he was really thrown to the wolves. And people say that he was always being nurtured for the job, … [that he] didn’t deserve the position because he was fairly inexperienced. He’s very young, and he fell into the position because he was liked by management further up, and I think people saw him as a bit weak and a bit young and inexperienced, and he probably didn’t have the respect of staff before he started … That’s a very hard thing to do … to earn people’s respect. People see that he’s come into the role … hasn’t changed a thing. He’s rubber-stamped everything that was done before, he hasn’t made [or] introduced anything new. Then you’re never going to please everybody … That’s why a management role is so difficult because [if you] try to prove yourself or to think that you’re going to be friends with [all the] people in the unit – forget it.

When asked about how medical management was organised in the unit, Alex’s response displayed some conflict. What she believed to be an issue in nursing she did not describe as a problem in medicine.

[The director] very rarely is in the unit … He’s one of these … people that can be away from the area for a year and come back. And I think it’s because he has this overwhelming confidence … and you think, “Gosh if I was in here, I want you looking after me” …. He is one of these exceptional people that is great at the bedside as far as clinical knowledge goes, but he is also able to manage the unit very well. That’s a pretty rare combination to have … it would be great if he was in there a bit more and saw what was going on. But he does seem to manage it very well and he does seem to have the respect of a lot of the staff … probably because 90% of the people are intimidated by him, but there again I think people do respect him for just how he does it. And doctors tend to function not as a team but as individuals. The consultants, when they’re in the unit, they’re the head … everybody is answerable to them …. But they don’t have to answer to anybody else … They do [answer to the director] … but I don’t think they’re accountable to a degree that we are … because even our nurse
manager is very much accountable to [the next level of nursing manager] ... Every
decision an ACN makes is put to [the manager].

It appeared that the medical director fulfilled all the requirements Alex had for a good
manager, in direct contradiction to what she viewed as necessary for a good nurse manager.
Does the medical director perform such a wonderful job or is this an assumption based upon
confident behaviour, and beliefs of male and medical superiority? My observations of rapid
changes in patient treatment according to consultant preferences, and the verbal abuse,
physical threatening, and intimidation of female nursing staff, concluded that not all was
well with medical management and that the contradiction related more to the competing
discourses of male medical supremacy and the tension this created with the subjugated
discourse of equality.

The marginalised and subjugated discourse: Management as superfluous and
unnecessary—*He polished up the handle so carefully that now he is the ruler of the
Queen’s navy*

This further marginalised and subjugated discourse concerned tolerating management and
viewing management as superfluous, to some extent unnecessary, and a little
disrespectfully. In this marginalised discourse, management was not viewed as a superior
occupation to clinical nursing. This was usually only expressed by individual nurses who
exhibited a reasonable amount of personal self-confidence and who expressed a significant
prior grievance with nursing management. Concepts of management were frequently viewed
in this discourse as rhetoric, and holding a management role was not assumed to indicate
either greater personal ability or prestige.

Sam reflected on her experiences with a nurse manager, displaying some scepticism and
contempt.

*I think he was threatened by me to be honest. I always had to approach him for things
... I was always up front with him and perhaps that was the reason why ... He
interviewed me ... when I first went there and I think I must have preempted his three
questions because ... he said “well I have got nothing else to ask you” and sort of
looked at me. And then when I came into the unit he really didn’t make himself known
to me. I think he was immature for the position. He was a person who was easily I
suppose moulded to what she wanted. And I don’t think he had the ability ... because
he had always been in that unit, to draw from other experiences.*
Sam further described her views of management in respect to being offered a new position at another hospital. She was confident of her own abilities to fulfil the new position offered, however, she questioned the assumption that she should want this new position and title.

[They] have given me the CNS description and want me to apply and are chasing me around the unit to get CNS ... “Well” I said, “you have got to sell it to me harder”. You know, I am making these people work, and sometimes I think that's good too ... I am not going to take it and say “yes okay, I'm worthy of it” ... but they are chasing me ... I am challenging what it's about, you know. Well yes, I am worthy of it but does it fit well with me? Is it sitting well with me, you know? Is it really something I want to commit to? And it's funny, they stand back and they go “oh” ... Yes, but I know I am worthy of it. So what's so different about me? Maybe it's when I left nursing ... [and that I] now know I can be successful other than in nursing – I had a senior management job. I was successful – got promoted quite quickly. Maybe I know that I can do something other than nursing. Maybe I created myself with options.

Sam questioned the desire to adopt what was assumed to be a prestigious identity. Her challenge of this dominant view she reported to be met with some incredibility. A nurse would usually, without question, readily assume this perceived prestigious identity with little work from others. Sam’s potential move from what she perceived as a more prestigious unit to this position may have raised her awareness in respect to her identity and stimulated her challenge to the conflicting processes involved in forming her own identity. Sam also openly indicated an awareness of game playing and participated in this simulated game with her talk of commitment and worthiness. Deetz (1992b) has argued that choosing sometimes to explicitly reject a move within the prescribed game and choosing to fail, or to play another game, can resist managerialism in everyday activities. Game playing however Sam viewed as separate to the real world, and she indicated a strong sense of individual freedom and control in the game rather than any notion that the real world in which she daily participated could similarly be a construction.

The legitimacy of the articulated discourses of nursing management was also challenged by Leslie who alluded to the fact that she believed much of what was articulated was accepted due to a lack of understanding by other nurses.

I think [the nurse manager] was employed to change things ... [but] she is very good at rhetoric and she won them on rhetoric. Unless you really know what she is talking about, you wouldn’t know that it’s a whole lot of crap.

The acceptance and lack of challenge to what was articulated is consistent with the subservient junior novice subject position. With little challenge to what was articulated then reality was poorly contested and instead constructed from dominant discourses that support
existing relations of power. Whilst the articulation of Leslie may be viewed as unconventional or conventionally unscholarly, it reflects however the dispute of discourses extremely clearly.

Val indicated he was aware that not all nurses on the unit valued nursing management and that many nurses were sceptical of the management role.

I think they have their own opinion as to what the role should be about … but I don’t think they fully appreciate what is involved … Until I got into it I didn’t. Whether that’s a failing on our behalf because we don’t actually sell what our role is or that we don’t communicate it … but at the end of the day I don’t think the staff particularly really want to know … I don’t think they really understand what the hell I am really doing with that time … I don’t think they expect me to be that clinically focused which has always staggered me to a degree. Someone recently said to me when I spent a number of days out in the ward … “I notice you have been out of your office a lot lately – haven’t you got much to do?” … One of my ACNs a few months ago … I saw she was really busy … she said, “how about you go and do your job and let me do mine” … which was again … that I shouldn’t have much involvement in the clinical management of the ward … So we had a good conversation about it at our [meetings].

In this description by Val he also indicated some rejection by clinical nurses of his ability to practice clinical work. As a mechanism of resistance to management processes, the individual manager was rejected in person, delineating distinct boundaries of expertise. Given the time constraints of a nurse manager and the dominant discourse that privileged management functions over nursing practice, maintaining clinical expertise was difficult for most managers.

The ability to challenge management thinking was hampered for nurses by lack of knowing the agenda and by a lack of confidence in their articulation skills. Ash talked about his experience of nurse managers’ lack of understanding and his expectation of nurse managers.

On nights you see [supervisors] … why do they need so much information about these patient[s]? … [They] come around and collect all this information … and I guess that they are really not understanding. What do they do? … Obviously they’ve got a role in coordinating things in the hospital but … well you don’t really see any[thing] tangible … I don’t think that they are really nurses. I don’t get a sense that they are leading … we don’t see them or hear anything real. [The DON] she’s quite visible and also I guess I’ve seen her once in the unit but she has had meetings in the unit and some are really boring meetings. But in terms of actions and outcomes it’s not probably a productive meeting … [She is not supportive] in terms of her attitude towards the critical care environment … she doesn’t hide … her opinions on staffing ratios … I’d
say she’s not directly supportive of me personally or the area that I’m working in … 
You don’t feel as if those higher than the unit manager are involved in leadership. If someone is going to be a leader and change things, surely they need to have support and understand the people that are going through … that change … If people are not satisfied with the changes then they often voice their displeasure by leaving. I can remember coming out of [a forum given at short notice] and thinking that a better scenario would have been to say, look a weeks warning – you can provide an agenda … I couldn’t think of anything at the time [to say] … I think think its just the way I am …. I often think of things after the fact. I quite like to – know if something is going to happen …. I don’t necessarily think about things quickly enough like that.

Studies by the American College of Healthcare Executives (1996) and Capazzalo et al. (1995) attributed poor self-esteem and confidence in nurses as a significant factor in women not gaining more senior positions within health care. This data supports the notion of nurses assuming subordinate positions, and that this subject position was actively reinforced and reinscribed by numerous unit and organisational practices including peer appraisals, meetings, routine surveillance for defects in ward routine by self and senior staff, and the processes involved in undertaking a postgraduate critical care course. Disciplinary actions, including lessons in process and the need to reapply for existing positions, overtly enforced this position, however, more subtle concepts such as equating new with novice and aligning nurses with poor intelligence also reinscribed this position. My previously described research position of acceptable incompetent also fitted the subject position.

Patriarchal and managerialist discourses informed this subject position although alternative and subjugated discourses were evident and included notions of teamwork rather than hierarchical relations, equality, and improved interpersonal relations and that of viewing management as superfluous and a little contemptuously rather than as a superior occupation to nursing. Studies conducted by Reverby (1987) and Nelson (2001b) highlighted nurse training to be about the development of behaviour and of a certain character to forge the ideal nurse that was submissive rather than independent, implicitly unquestioning, obedient, quiet, and with internalised self-discipline. Cheek and Gibson (1996) also identified the docile nurse and the discursive construction of that identity. The data supports that little has changed in the social construction of nurses within the clinical environment, except perhaps the technologies that enforce and reinscribe this subject position. Previous literature has identified that subordination to the practice of medicine and socialised suppression, as well as the perpetuated myths regarding nursing, eventually undermines nurses’ self-image and confidence in themselves (Kalisch & Kalisch, 1987; Malko, 1991). This data would suggest that the relations between nurses and nurse managers further undermined nurses’ self-esteem.
and confidence. Whilst resistance was often noted, nurses informed by dominant organisational discourses actively participated in constructing and reinscribing their own subjectivity and submissive identity.

**The detached unemotive individual—*The syncopated clock***

This subject position may be described as a position adopted by nurses whereby they were able to withhold personal emotions and appeared to be emotionally removed in interacting with others. Work was performed according to what was perceived as the prescribed role, irrespective of the actions and of the opinions of others. There was an aspect of emotional detachment or distance between the nurse and with whom she interacted so that a nurse in this subject position exhibited a clock-like functional focus. This position was adopted by nurses predominantly in relations with staff. The first entry in my field notes cited at the beginning of this chapter, regarding the lady who sustained head injuries, displays this unemotive position adopted by Tuin in an early interaction with myself, and then her swift change of position in an interaction with this same patient she had just cynically discussed.

The following is an excerpt from my interview with Tuin.

Tuin:  “If the wrong decision is being made – that I believe to be wrong, then I’ll have my say. If I am not agreed with then so be it … [I don’t get] real steamed up”.

Robyn: “You take it home?”

Tuin: “No”.

Robyn: “So you can walk out and shut off?”

Tuin: Absolutely. Get on my push bike and by the time I get home – forget it”.

The frankness of Tuin’s comments stunned me a little at the time. Toward the end of my time in the unit I was happy to accept Tuin’s words on face value, however, at first I was not so sure.

*I think something terrible must have happened to Tuin in the past. She appears to cut off her feelings and has some harsh opinions. I get the feeling she is withholding something and is testing me to see if I am safe or worthy of confiding in. Today she walked off and left me alone with her really sick and unstable patient. I prayed nothing would go wrong and managed okay but I felt it was a test of both my clinical skills and my nerve. I also get the feeling she is playing with me or trying to work me out … I will try to spend more time getting to know her and to see if she has a reason for why she sometimes appears to hold these rather brusque views.*

Despite long lengths of time with Tuin, she did not confide any great secrets and I thought somewhat ashamedly about how I was almost trying to extract a Foucauldian confessional from Tuin so that I could analyse her *problem*. I decided to accept her views and actions as
simply one subject position that she sometimes could adopt and that this did conflict with other highly sensitive and emotional subject positions that she also could occupy.

In this subject position, being tough and keeping an emotional distance was seen as necessary for survival and, together with being a manager, it equated with not being able to be close friends with individuals who were to be managed. This position was not readily adopted by Alex, however, she argued that it was necessary for her to adopt it.

People tell it to me all the time – you’ve really got to distance yourself from it being a manager …. And you’ve really got to not take it personally and that’s a really hard thing to do … I do notice that the ACNs and the managers do not have many close friends in the unit. That’s not to say they’re nasty people. I think it’s a very very difficult thing … it is one of the hardest things that I have found … It’s very hard to manage friends …. Hopefully people are mature enough and grown-up enough to see that you are acting in a completely different role.

The assumption and expectations by staff that managers cannot have friends supported and reinscribed this subject position, creating some social isolation for the manager. Jo talked about the difficulty of managers having friends.

Yesterday, one girl was saying that when [the nurse manager] was just like one of us, everyone would gossip with him. You couldn’t imagine him being like that … sort of like one of the gang [now]. You do have to, I think, pull away from the general gang … [You] can’t be talking about other people … [you] have to be a bit more sort of professional I guess. And people also come to you with confidential situations that you can’t pass them on to everyone. He said … the other day, “You know no one tells me what’s going on … any more”.

Management teams and the hierarchy that required junior nurse managers to support the decisions of senior managers and management teams reinforced this position of nurses not being able to have or maintain friend relationships or to display their individual opinions with other nurses. Meetings also played a significant role in ensuring that a uniform and established position was taken by those in management positions. Whilst a nurse may have held a contradictory personal opinion, they were expected to at least openly display their acceptance of the management decision. This public display blurred the boundaries between what was perceived to be an act (upholding management decisions and not showing personal values), and what was thought to be real (personally caring). It was apparent that neither clinical nurses nor nurses in management positions could clearly separate the difference. In addition, the notion that the real could also be a construction and the effects of that construction as a mechanism of control by self, was not articulated. It is interesting to note also that in the previous subject position Alex indicated that she thought the unit should be
more preoccupied with itself and stop being so concerned with the hospital as a whole, which she appeared to refute from this position.

You do [care about people] but sometimes it’s pretty hard to show them … It’s very important the management group as a whole sort of unite with their decisions … And that’s why in these management meetings when certain decisions are discussed you might disagree with it completely, and as long as you put your opinion forward in these meetings … once you go out of that room into the unit you’ve got to act, you’ve got to behave as a unified bunch or it’s not going to work. And that can sometimes be a very hard thing to do if you don’t agree with something … and you have got to turn around and do it. Being part of the management team, you’ve to accept that sometimes you’re not going to be able to have perhaps your own personal opinion. You’ve really got to go with what other people think … If it is someone who [you can trust then you can say] “Oh look I think it’s a load of rubbish but this is what has been decided” … [but] there is no backing down … I don’t think you can openly say “I don’t agree with it,” because … the manager [then] cops the full brunt of it. Part of being an ACN is to support … any decisions that are made … You’re working as one nurse in a small part of a big hospital and I mean we can all turn around and change something that isn’t going to be uniform throughout the whole hospital. You are obviously restricted from above, and I think that’s one thing that the nurse managers can and might find very difficult.

Alex explained that becoming tough arose from having to make decisions that other nurses would not like. This role was assumed to be the inevitable or natural role of management. The instrumental and patriarchal discourse of management was evident, along with the notion that it was not good to be weak. Alex said

Before I became CNS, people would come to me with all sorts of issues and problems and things like that. But then when they saw that I’d moved ‘up the ladder’ … a little bit, and I almost became one of them [it changed]. … I don’t know if it’s that they don’t trust me, [or] they don’t feel that you are as approachable … because that’s really when you would like to say that you are approachable … I’d hate to think that I had changed. Maybe I have to a certain degree because I think you have to [and] maybe I’m not as approachable to them … Maybe I have become a bit less approachable in having to become a bit tougher … You do need to make decisions that people aren’t going to like … You are part of the team that make decisions that people aren’t going to like, and you do need to become a bit thicker skinned … because otherwise you are not going to last. You are not going to survive … because you just can’t go along … being weak. You just – you can’t.
Alex further indicated, similarly to Val, that there was a degree of resistance to her role from clinical nurses, in the form of personal rejection. This is consonant with much of the literature that has explored the experiences of nurse managers and identified significant experiences of loneliness (Davidhizar, 1992; Persson & Thylefors, 1999; Silvetti, 1990, Traynor, 1994), and administration bashing (Silvetti, 1990). Patriarchal and managerialist discourses were evident that equated emotions with weakness which were not viewed as commanding the respect essential for management. The identity or image of the management team and the organisation was viewed as paramount and privileged to the identity of the individual. The resultant effect was that managers became a human target for resisting staff. They also assumed the unified unemotive position of the organisation. Alex explained

Not everybody understands what the ACN role is and there also might be a bit [of] “You wanted the job so you do it.” Only six months ago, there [weren’t] any nasogastric pumps left … I was quite busy with something else and [a senior staff member] said, “You wanted the position you find your pump”. You suffer the consequences because you’ve got to take the flack that comes with it. It’s not fair but I think it all comes with it … it’s human nature. There’s not anyone else to attack – then you attack the person that’s doing it. At 10 at night someone came up to me at the desk, a very senior staff member … and just chews these rosters up and says, “They’re a load of rubbish.” Then it’s so hard to stand there and take it … and you don’t want to cause a scene … you don’t want to argue … it wasn’t justified what she was saying but … I had to cop it, there wasn’t much I could do. I could say, “This is what’s been decided and this is the way it’s going to be.” They didn’t want that answer … There again you can be nice, you can be seen as a very weak “yes” person … [but] if management [isn’t] united … there is all sorts of strife because the management team, as a whole, isn’t respected. You might lose some respect for not speaking up for yourself, but the management team as a whole needs to keep their – or I hope they do, keep their respect.

The patriarchal instrumental discourse of managers being tough, and therefore usually not overly liked, heavily informed this subject position. It was perceived normal for managers not to be liked and Alex attributed her desire to be liked to an individual personality trait which she assumed was something she couldn’t have as a manager. Respect in a relationship, however, was the goal to be achieved, which again was a position of detached superiority rather than a friend. A manager could not be a friend, and this transgressed into social relationships outside of work such that once the identity was assumed it was hard to shift from or convince others that other identities could also co-exist. In her interview, Alex explained her thoughts.
I’ll never forget the first shift where … I put one of my best friends in step down … She laughed it off and although in hindsight it was a very trivial thing – it was like, Oh I don’t like this … I suppose it’s personality though … I like everyone to like me so to speak, and you can’t. Not everybody will like you. People will respect you, but there’s a bit of difference I think between respecting you as a manager and seeing you as a friend. People find it very hard for example to socialise with [the manager] outside of work. People still see him as nurse manager … I’m sure people think that I’m going to go back to [a management] meeting and say that such-and-such said this, this, this and this … I’ve only been to a handful so far, but from the outside they’re frowned upon … as a bitch session …. Although I’d like to think that I am approachable because I think that’s the number one thing of being a manager, I think you do lose a bit of that in becoming a manager.

The assumption that a superior boss was essential and that conflict between staff was a result of female deficits was inseparably informed by patriarchal and managerialist discourse. Tuin accepted the hierarchy and female deficits stating, because there has to be a boss anyway … I have never worked anywhere else but that’s how I imagine it to be. I guess it’s more bitchy than most places because it is full of women and I imagine because there is so much more casual labour you know.

The assumption that full-time employment was the desirable normal also reflected patriarchal assumptions held in a highly masculinised model of work.

The perceived detachment of the individual person from the role of the work displayed this subject position and was articulated clearly by Naz.

There are individuals around here who see … our managing of demand as trying to reduce their power and reduce their turf … it’s personal. I actually think I’m here to do a job. It’s not about me quite frankly.

Naz described a mixed position of both detachment and yet desire for further connection with nurses when responding to questions regarding how clinical nurses perceived her role. Naz talked about the importance of connecting which was a predominant concern of hers and which she articulated throughout her interview and practiced by prioritising time to meet with and talk to nurses frequently. The large size of the organisation was attributed for the difficulty for all nurses to know her personally, however, this large size was not considered something that could or should be altered, nor does she view it important from this subject position that staff should know her or what she thinks personally.
I don’t think they understand any manager’s role. … People tend to only understand it from their perspective and I guess one of the biggest challenges that we have is trying to connect with people … [It is] a little harder than I expected from the perspective of people wanting me personally to be responsible for things. My view has always been in a place as complex as this [that] my job is to develop a team which then went and developed managers who then went and developed staff. I personally can do nothing to affect the everyday reality of the nurse, unless I do it through other people … It’s like – I don’t understand it … us and them or this perception that I personally could know about their … personal reality. It’s a bit unsophisticated and naïve that they think that I should. That they can’t understand complex organisations. But I guess it’s the same as, you know, talking about the people who have intense interest in one area and a great passion and they can’t grasp the whole organisation. And I don’t expect them to be able to grasp the whole organisation. What I’m a little surprised at is how minute they are in the sort of shallow responses like there’s something wrong with the fact that I can’t know their reality. And to me I could expect that they might not know me personally, that they wouldn’t necessarily know what I think, but why is that so important if their work environment is okay?

This detached position was related to a show of appearing confident and perhaps even a little superior, which I also easily slipped into. This tended to occur in situations where individuals felt they were being judged and were keen to fit in or display the required behaviour. Displaying scientific knowledge, technical expertise, and confidence ensured that individuals were not perceived as emotive and weak.

I find it difficult to re-engage as a critical care nurse and realise I am being viewed with some mixed and guarded opinions of nurse academics by both clinicians and nurse managers. I find I am frequently using ‘tough technical talk’, that is, lots of abbreviations, complex medical language, and very little emotional content. I am not sure if this is a defensive position as I frequently feel I am being judged to see if I am ‘a worthy nurse’, but it seems necessary to demonstrate this as my expertise in order to be accepted. It is, however, counterproductive to engaging in any conversation of any depth with nurses about their feelings and experiences.

Despite the difficulty of engaging in conversations of any depth with nurses in the clinical field, this isolated, technocratic, functional clock-like position was adopted by myself and other nurses only at times, and marginal and subjugated discourses to this subject position were also evident.
Marginalised and subjugated discourses: Collegiality and mateship—
That’s what friends are for

Marginal and subjugated discourses to this subject position included a strong sense of the importance to individual nurses of things they described as mateship, collegiality, friendship, being one of the flock or gang, and connection. This has been articulated in the literature by Westmoreland (1993), who concluded in questioning the belief that separation and autonomy were the hallmark of mature behaviour and instead suggested that connection and relationships, which are significant in the role of nurse managers, should be viewed as strength.

Sam talked of changing conceptions or relations between nursing staff and stressed the need for mutual support.

We have to support each other a lot more. I think we have to change our focus instead of saying so and so didn’t do that right. Oh God she’s a bad nurse. Instead saying [that] well maybe she was just busy she didn’t get around to it and it’s 24-hour care. It’s all right. How can I help you? And support each other.

The importance of relationships was also articulated by Naz.

I do believe effective managers and leaders are … all about relationships and people … You expect maybe they’re arrogant and ego driven and all that stuff. The really good people aren’t. It’s the middle managers who are. They have to be able to trust you. But it’s not because you make decisions for them. Leadership is having a vision for something, wanting to achieve something and getting people to go along with you. It isn’t because you’re decisive. Every leader in the world isn’t a charismatic sort of person. Some are quite thoughtful and quiet and they receive tremendous loyalty from other people. Not because they’re up on the front of the stage or leading the parade, but because they’re solid and because they tap into other people.

Tuin also spoke from this discourse identifying a problem of isolation for managers.

I like the way we all have lunch together … I think that is very positive. I hate it when you get staggered lunch … You never see anyone in the coffee room. If the team didn’t work then the whole philosophy would fall on its feet wouldn’t it? I don’t think my manager has anything to do with that to be perfectly honest. I think that that all just runs by itself. When my manager isn’t here it all still ticks over so I don’t feel as though he has any input into that … When you are a manager you just get isolated. Unless you are on the floor, I think you would be entirely isolated as to what goes on. Because nobody wants to be your mate.
This alternate discourse of mateship or collegiality was marginalised to the dominant instrumental and managerialist discourse of economic rationalism. The effect on managers was noted by Sam.

People have a perception of you when you are one of the gang, one of the workers. And suddenly you sort of jump the fence and next thing you are sprouting management theories and management directions, strategic plans – and its like you’ve left the flock. And the nurses do see that. They don’t see like you’re on their side any more … some people see it as betrayal. You can sometimes be the meat in the sandwich as a nurse manager and try to appease the staff and give them what they want to do their job, and make it easier. And then on the other side you have got a management team manager saying you have got to implement this plan. I really don’t think they get [much choice] because the bottom line is budget driven.

This alternate or subjugated discourse was also evident when Jo talked about her experience of what she thought was a good manager. The arbitrary but distinct separation assumed in male discourses between work life, private life, and the associated expected behaviours was significantly diminished. The patriarchal concept of good manager behaviour that attempted to separate these spheres was contested, and behaviours commonly derogatively stereotyped with women were viewed as important. These behaviours were quite overt and not those usually attributed in the literature to be the virtues of women in management, such as democracy and collaboration (Gardiner, 2002). Not only was this manager perceived by Jo to be a good woman, she also overtly displayed behaviours commonly denigrated with women.

She was like one of our mates, kind of thing. She got along with everyone really well and everyone respected her to deal with whatever was asked. If she asked you to do something you would really put your heart and soul into it. But she was also like a real good confidante and friend and she was a really really good manager … She used to come out on away-ward functions … and invite us over to her house for like celebration parties … call us up at home and that kind of thing. Plus it was a much smaller unit and she was also like a very outgoing vivacious sort of person … I don’t know if it’s me, I’m not sure … like she was female so like she could sort of perhaps join in on a lot of female things. Talk about make-up, hair or clothes and stuff like that. [I] felt a bit more of a bond I guess. She was around more as well. I think [our manager] like he’s very much like in his office or he’s at/in meetings.

The notion of mutual support and collegiality was also supported by Naz as she discussed her response to an external decision that she felt was going to make the lives of nurse managers difficult. This was not a regular occasion.
[It was] going to be tough – the only people that we had to count on were each other .... And so that what I propose[d] was that “we pick a night and go out together somewhere. Go to some place locally for two or three hours and just have a good time … because the only way we are going to get through this is through each other and yes of course we can’t fix it … but collectively we can get through it if we pull together”. [It’s] important to me in keeping that group together … have the sort of trust and support and colleagueship.

Jo talked about how she felt she needed to be supported and described an incident in another hospital where nurse managers had not supported her. The incident she described occurred after she documented an unsuccessful attempt to get a sick patient in recovery reviewed by an anaesthetist.

I got to work and my manager came storming out to me “... get into the office now ... this is really bad...”. She just like absolutely ran riot through me and I had to see the director of nursing and all this kind of stuff. They said, “You have to apologise to the anaesthetist about what you had written”. I said, “I’ll apologise that I made her feel you know, horrible or whatever, but I’m not going to apologise for what I had written”. Apparently the anaesthetist was going to the Board of Anaesthetists to complain about me and all this sort of stuff. And I just got no support from my manager whatsoever [or the] ... nursing manager above that ... and I was in tears ... [and] absolutely distraught. I left because I felt really unprotected knowing ... if anything really bad did happen, I’d have no one to like be a confidante or no one to rely on.

The concern of critical care nurses regarding lack of support, trust, and good interpersonal relations with nurse managers has been previously predominantly documented indirectly (Bailey et al., 1980; Cartledge, 2001; Cox, 2001; Dracup & Bryan-Brown, 1999; Gardner & Pierce, 2002; Goode & Rowe, 2001; Huckabay & Jagla, 1979; Sawatzky, 1996; Sundin-Huard & Fahy, 1999; Suominen et al., 2001; Turner & Ogle, 1999). Mumby and Putman (1992) advocated a form of organising that sustained values of nurturance, caring, communality, and supportiveness and where the bonds between people were less instrumental, more enduring, and where there was an enhanced sense of community and care. The importance of feeling safe, being supported, and also of the unit being cohesive, was further elaborated on by Jo.

I think my current manager and ACNs have been responsible for like a very cohesive unit at the moment. I think that’s got a lot to do with the type of manager we’ve got, and like you always feel like you’ve got backup and you can go and see them about anything. And they’ll listen to you and you know they’ll be confidential about it ... [Therefore] everyone feels quite safe and secure ... [There’s] a nice feel about the unit
... It's not like you've got these people who are ... sitting at the top of a ladder going, 'You will do this ... You will do that'. And they are very much our managers at the moment. They'll ask everyone how they feel as they go about situations and what we think.

The issue of support was of great concern to Jo who later in her interview changed her position in relation to support within the unit. She commenced permanent night duty to avoid the problem.

Where I [previously worked], that was a really good unit ... and everyone would discuss and have much more of an input than we do ... [Consultants here] might be trying to run off down the hallway to get away from the questions that you have to ask. I've actually gone on to permanent night duty and that's one of the reasons why because I find one of the really stressful things is ... you'll go home on a p.m. shift, come back in the morning and everything will have been changed with your patient with a different consultant. You come back on and think, 'What was all the changing and chopping around on the last shift for' ... and I find that really frustrating and confusing. Some of the consultants like drying patients out, some of them like them a bit wetter you know. All these lovely little things ... I just got to the point where I couldn't handle dealing with [the medical staff] any more ... They didn't listen to what your opinion was. They could be very rude and very arrogant. Sometimes you get the inkling if you say 'black' they'll say 'white' just to go opposite to what you say. You just don't deal with them as much on nights. I was thinking that I wanted to leave ... I saw [our manager] about it and I said, “the only other thing I can think of is going on to permanent nights for a while ... because I'm not enjoying coming to work”.

I asked Jo if senior nursing staff attempted to deal with the issue of medical staff and if the manager suggested addressing the medical issues when she indicated it was a major reason for her request for permanent night duty. She responded

No not really. I don’t know, maybe no one else has broached that subject with him. I’m not sure if everyone else sees it the same way as I do. Like I know that people get frustrated with [medical staff] ... I’ve not really had big chats to people. You sort of complain about it but ... I don’t think [the manager] has a lot to do with the medical staff ... I don’t know how he deals with that or what their communication situation is like. And the ACNs ... they’re there on the rounds but they rarely will bring issues up. They’ll generally leave it to you ... I would like to see more medical staff respect, not just nurses but people more in general ... For instance, they just walk straight up and whip the bed sheets down [on patients]. [And I would like] a more collaborative approach to patient care. It’s a matter of sitting down with firstly like senior medical
staff and discussing the matter with them and actually letting them know there is a problem. It probably is more – a management situation – to be advocates for staff members in that regard … I don’t think … it’s really been brought up as an issue in our area. In other units … I worked in it was very pro-active in regard to … nurses getting treated well. It was sort of more a whole hospital thing. It was a very unionised hospital whereas [this hospital’s] not and nurses were very like proactive and quite gung ho about their rights and that kind of thing.

Within this subjugated discourse of valuing others and valuing friendship, the notion that horizontal violence existed was expressed. This is normally absent in dominant discourses that assume work relations are well integrated and unproblematic. Jo explained

Sometimes it’s just a matter of being friendly as well … I’ve only really started like probably in the last year to be really settled into the unit and have a lot of friends in the unit. At work I have a social committee which a few of us have started up … [so] there’s a lot more social things going on. And a bit of that helps to filter out the horizontal violence, because you become friends with people at work and … you are doing things outside of work.

Friendships and friendship acts were evident in the unit, however, this was mostly visible on night shifts. Significant social interaction occurred in the unit on night duty but this was strictly limited to the tea room during day shifts when its intensity was also considerably diminished. This could not be attributed to the notion that during the night shift, relatives, doctors, and senior staff were absent, as in this ICU they were frequently present at all hours. The nursing supervisor also passed through without a display of concern for the social activity. Many nurses explained that this social aspect made night duty more bearable. It appeared the social rules for day duty constrained what nurses would have liked and that this rule was mediated on night duty, perhaps to appease nurses when they were more reluctant to attend.

The unit is supposedly quiet tonight. Small groups of staff clump at the end of several of the beds on stools and chairs chatting informally whilst maintaining a vigilant watch on the patients. Intermittently they attend the patients according to what is required for their care. The consumption and sharing of food is a central focus and the atmosphere is very inclusive, extending also to me although I feel it is still very evident I am not staff. A large trolley is laden with food brought in by staff and wheeled up and down the long corridor formed by the line of bed ends dotted with groups of staff. This starts a while before midnight when all the afternoon staff have left and extends throughout the shift until most of the food is eaten. The tearoom is empty. The sharing is very inclusive with everyone working as a team to ensure that all staff, including myself, have several opportunities to sit in a group and partake of
the food. They attend each other’s patient frequently in this effort with very good will. I feel guilty when I reflect upon what a treat it is for these nurses to sit and talk and compare that to my researcher role. It may go some way to explain the tension that sits between nurse clinicians and academics that I have found. My food is not home made—most of theirs is. I have only admiration for what these nurses do.

The sharing and consumption of homemade food and social events has been previously cited in studies of nurses (Valentine, 1995; Valentine & McIntosh, 1990) and noted as an attempt to ameliorate conflict and strife with interpersonal connection and friendship.

This subject position was informed by instrumental and patriarchal discourses that equated management with the masculine notion of being tough and not displaying emotions. A manager relation could not be one of friendship. The manager’s role was to make tough decisions and, if they did not, they were viewed as exhibiting the poorly viewed feminine trait of being weak. The practices of manager meetings, the requirements of junior managers to unequivocally support higher management decisions rather than hold individual opinions, and the technique of conceptually separating the person from the role, all aligned the individual with the identity of management and reinforced and reinscribed this subject position. The notion that managers must uphold respect rather than friendship reinforced the superior but distant position held in relationships. This subject position was adopted predominantly in relation to other staff rather than with patients. Resistance included rejection of the role, which therefore entailed rejection of the person. This added to the experience of distance and loneliness for managers, which has been previously documented in the literature. Marginal and subjugated discourses of mateship, collegiality, and friendship were evident, however, they appeared to require some negotiation. The associated practices were often hidden, relegated to sites away from work, and were limited to unusual or special occasions. Patriarchal behaviours that displayed a distinct separation of personal life from work life were contested, and behaviours and activities often denigrated and stereotyped to be those of women were valued.

The pleaser—The joy bells
Within this subject position, the nurse was extremely keen to please other individuals and/or a system of people they perceived had some power over them. The desire to please involved practices of silences and inactions, as well as actions. It was not a position of equality and friendship, as the pleasing role was always adopted by an individual who either perceived they naturally should please others, or they needed to adopt this position and please others in order to achieve their own ambitions. Words frequently used to describe nurses taking this position were the yes person and the compliant person. However, it was often evident in the
everyday numerous subtle actions and views held by nurses. Furthermore, it differed from
the subordinate position in that there was often an active desire, and this was not essentially
associated with assumptions of natural inferiority in respect to experience or knowledge. It
was often significantly aligned with either maintaining or improving the individual’s
perceived position within the nursing hierarchy.

Similar type positions adopted by nurses have been documented in previous clinical
ethnographies describing the nice nurse (Street, 1992), and the good nurse (Alavi & Cattoni,
1995; Glass, 1998). These were similar to the pleaser position described in this study,
however, this position of pleaser also incorporated a strong sense of desire. The significance
of this desire was in how it could be constructed and created to direct thoughts and actions.
This concept of desire is consistent with the work of Deleuze and Guattari (1987), and
Foucault (1988a), and has been previously utilised by Calás & Smircich (1991) in respect to
the seduction of leadership literature to impose closure on what is said to be organisational
knowledge. Baudrillard and Poster (1988) also contended that seduction was dependent on
the lure of withheld knowledge and the unattainable desire to be an insider. Several women
participants in the study by Robinson-Walker (1999) noted that because they were women,
they believed they were brought up to be pleasers.

The pleaser position was often readily adopted by nurses in everyday subtle ways. Latu
described the issue of night duty, which was a thing most staff abhorred, and how she
believed staff readily made concessions to please management.

> You are often asked to do as senior staff an extra week of night duty and some of us
> end up with more than others. And you think no not again but you are quite within your
> right to say ‘no I have done my fair share and I have done extra’. But a lot of staff don’t
> like to say no.

The difficulty of saying no was also reflected upon by Val.

> It’s really hard for me to say “No”. I’ll be packing up looking at the clock saying “Oh
> God I’ve got to be gone … I’ll be walking down the ward and someone will grab me
> about something or that, and a 5 minute things turns into 15 and a 20 minute
> conversation. Sometimes, if I really just don’t want to get caught, I’ll sneak out this
> door and won’t walk down the ward, but I always like to say ‘Bye’ to people … so it is
> really hard. Then [my manager] will say, “Look, can we just catch up at 4.30 on this
day to do something because it’s a quieter time in the afternoon?”

Clinical practices were often dictated according to what was liked by the collective we rather
than according to any specific evidence or preference of individual nurses. Nurses were
expected to change their practice to what was commonly understood to be correct and liked
within the unit. A unit manual outlined some specific practices that nurses should follow which were documented and signed by the medical director of the unit. However, specific details of ethically contentious practices such as ceiling treatment (the level of care at which active treatment stops), was very often verbally communicated and understood between nurses. These clinical practices that were understood by nurses to be the correct practice were therefore liked, and nurses saw it as their responsibility to enforce their compliance. This both standardised and normalised nursing practice, with nurses becoming the technology that implemented the practice. Alternative practices were relegated to be other and their use did not please either nurse managers or other nurses. Latu reflected on how she changed her nursing practice after commencing work in the unit.

[There was] a certain way of doing things … and when I look back now you say well that’s just the way we do things. But when you first walked in … [it was] “we tie our arterial lines and secure them in this manner”. And mine were pretty good and secure, it is just that I had been shown other ways of doing it so I had done it that way. You know, “we like to do that here”. And then you just get ingrained in and end up doing it.

Leslie described how strongly the desire to please could be, to the extent of individuals being perceived by other nurses as being an informant or snitch to management.

Every now and then it’s obvious that information has got through to management by somebody snitching … and then you don’t know who you can trust. That’s a very unhealthy attitude to work with. There is a girl at the moment who was trying for CNS for some time and was having problems getting it … she’s a little bit naïve and young so [the manager] has almost used her as a snitch to infiltrate into telling what’s happening … because she was so desperate to get that CNS. And now she’s really desperate to get an ACN position. She came unstuck recently because [she told the manager] something that a friend had told her … who confronted her on it.

A similar notion of pleasing was described by Latu, who talked of her experiences and the actions of other staff in the unit following her decision to leave the unit.

There are certain people who … think the sun shines out of the nurse manager’s rear end and will do anything to please—you almost think they are spies. You say to someone “I am going to leave. Please don’t say anything to [the nurse manager] as I would like to tell him myself.” And then he hears about it. You know I have only told certain people so one of them had to have told. And I have specifically said “don’t tell him—I want him to hear it from me first”. The ones that are climbers, they will do anything to get there … and they don’t question and they don’t change anything. They say yes to anything and everything—I am happy to work an extra shift—I will work on the weekend—I’ll do anything—I’ll sacrifice.
I observed one nurse manager recruit a nurse into the role of an informant toward the end of my time in the clinical field. I had been told there were problems with staff in a ward.

I am a little dumbfounded. This nurse manager was fully aware that I was closely observing nurses and nurse managers and freely spoke on the phone to a nurse on maternity leave. It was requested from the nurse that she returned to work on a specific ward to help find out what was going on. Whilst this was not ideally what the nurse wanted, it would be of a limited duration after which she would then be assigned project work. I can’t work out why it was perceived to be okay to carry on this conversation in front of me except that I would think it okay. Are my values outdated or perhaps I am a bit naïve? I rescind any scepticism of previous claims I have heard. Even if the circumstances warranted the action, the unapologetic blatancy of it worries me.

Inactions so as not to displease superiors as well as actions comprised this subject position, however, it was not always willingly adopted by nurses. Desire for a future goal or apparent position of prestige was often the central motivator for nurses in adopting this position. Latu did not personally want to please nurse managers as she was already upset with several, however, adopting this position was expected behaviour in the unit, and she felt it was necessary for her not to further displease her managers if she wished to gain promotion. She explained her inaction or decision not to seek union assistance following what she thought was an unfair performance appraisal.

A couple of other people got appraisals that weren’t very favourable; purely on personality. I was asked would I take it to the union. At that point I said, “look I really would like to but I feel if I do I won’t ever get it and I will end up far worse than what I am”. And I was probably too afraid to do anything .... I did want to get the CNS position and I thought if I had any chance of wanting to move up or promotion in this unit or any hospital I wouldn’t get it if I had gone.

Latu further described how she felt about the process of attempting to obtain a CNS position and what she had done in relation to her CNS application.

I felt like I had to do anything – if that’s what you had to do. I did X, Y and Z – what was considered necessary to put in your application for CNS. So I would do that. I felt like a little dog. I told them I felt like a little dog having to jump through so many hoops. I would get to the end of the circuit and you tell me to do it again – and jump through these ones. And I have done everything you have asked of me and still no.

The requirement to please and exhibit certain pleasing behaviours arose in part from the creation of desire for a prestigious and often allusive position. Tuin described her thoughts in
respect to the process of obtaining a CNS position, referring to it as a process with a teaching purpose.

All it serves is the purpose to teach you how to eat humble pie—that’s all.

It therefore directly linked with and reinscribed the inferior and subordinate subject position. It is interesting to note that Sam’s response to being chased for a CNS position (as described in the junior novice subject position), differed greatly to that of most nurses. The desire to please was absent when the new position was perceived by her to be inferior in status to the position she had previously held.

The subject position of pleaser also entailed exhibiting certain behaviours aligned with a prescribed personality. Deetz (1994) argued that most modern organisational decisions and practices reflect more the constructions of “appropriate individuals than the making of products, services or profits” (p. 24). My observations of nurse managers were consistent in that staff development consumed far more of their time than activities related to clinical patient care. Latu explained her experience of being perceived to have the wrong personality.

You had to be this smiling lovely personality all the time … Hello – How are you? … Good morning personality. If you spoke badly you were taken to her office and told you spoke badly. She didn’t like some of the older senior staff who had been there for quite some time as they had certain personalities which clashed with her version of what a ‘crit care’ nurse should be. I got into trouble for things like having a bad day or being a bit premenstrual. It was pointed out in my peer review that I didn’t smile enough. That I … ‘look unapproachable’ … Well I probably was … I have someone who is critically ill and they are ‘swaned’ and have lots of inatropes and I am concentrating and fiddling …. But that wasn’t acceptable … and I left her office in tears. There was not one clinical fault found – it was all about personality. I was told I could go and do an external personal development course or something like that.

The experience of having or displaying the wrong personality was also described by Leslie who explained how her personality was perceived as a problem, resulting in lack of promotion, recommendation of remedial courses, and disciplinary actions to rectify her problem.

I had applied for promotions for ACN positions [and] for nurse manager positions and [for] the last one I didn’t even get an interview. When I went to the ADON to ask why she said “oh it’s a more substantive position”. I thought that was interesting seeing I had actually had previous experience as a manager. And of course the person they employed had less qualifications and less experience. That’s what I expected. But all during that time – several years … I always felt persecuted and every time I got an
appraisal it was always focusing on my poor interpersonal skills. My clinical work was always fine but it was always focusing on my personality and that I had to change it. I was just too threatening … and apparently a small number [of peer reviews] said that I was unapproachable … I was intimidating, those sorts of things. It didn't worry me because I remember when I first started in intensive care I thought everybody was unapproachable and scary. But it was just because they knew so much and I knew nothing. I thought well that's all right, most people obviously think I'm okay and as people get to know me they will realise that I am all right. However, my personality, and me in particular, was never supported and especially once [the nurse manager] started because she had this sort of pie-eyed idea about everybody being friends and everyone getting along with everybody else and no recognition that this is intensive care. Things happen in a hurry – you have to make quick decisions. There's often no time to beat around the bush and be fluffy in your approach. She wanted me to have supervised practice and to work every shift with [a nurse manager] who has now got promotion and at the end of each shift I would have to sit down and have a chat with [this nurse manager] to see how I went.

Deviation from the prescribed pleaser position resulted in the individual being constructed as being abnormal or having a problem. Many participants described self-doubt regarding their own personality, including that of Leslie who reflected,

I always thought that if I left because of how they treated me they were winning and I didn't know what else to do. In some ways I felt I was in a bind because I wouldn't get a decent reference. But I thought well I enjoy the work and I enjoy that challenge so there's no point. And I hadn't heard of any other unit that was so fabulous that everybody just loved it … Of course by that time I had started believing that I was unapproachable and difficult and all the rest of it – that I had these basic personality flaws. There was something in me that said "its crap, it's just them" … but I got told it so often that I started wondering and I suppose because they treated me like that I became very cynical.

The reinscription of an expected personality was reinforced predominantly toward those nurses who were perceived to have deviated from the expectation, and therefore became a problem. Self-surveillance and peer appraisal processes interconnected and reinscribed this normal expected behaviour enforced by the disciplinary technique of performance appraisals. For nurses with poor self-esteem, it was a very effective mechanism of control. The constructed nature of normalcy and use of performance appraisals to discipline was also evident in the arbitrary nature of to whom and how far this expectation of normal personality was enforced. Leslie described the arbitrary expectation.
It was only those of us who were difficult [who had to smile]. If you were compliant it was okay to be a bit surly at times and certainly laziness wasn’t the problem … but if you rooked the boat.

The subject position of pleaser was reinforced by those not conforming being identified as problematic and being seen to require remedial action to correct the anomaly. Personal development courses were suggested and recommended to fix these so-called problems. Unfavourable performance reviews and withholding promotions were techniques and practices that reinforced this subject position. In addition, group meetings, self and peer surveillance, and the practice of peer review, served as mechanisms to reinforce expectations regarding the behaviour of nurses.

Latu commented on this issue of peer review and how she felt watched and reported on by staff.

You would sit down at tea and think who could say this and say – ‘it could be you, could be you’. What about you? Was it you who wrote that? It may have well been. I had a bad day. I had a stressful day or I had 3 patients dying in the last 3 days and I am just feeling not quite like I want to be there.

A discourse of problemlessness also informed and reinscribed this pleaser position. Being a pleaser involved espousing the discourse that all was well, not raising problems and that current activities and the current status quo should be viewed positively and maintained.

Latu described this issue.

In ward meetings I would say, “Hang on a minute I really don’t know about this because” – and you just bring [something] up in conversation. And then the glare is just obvious there and you think I shouldn’t have said that because you are challenging or questioning.

Latu further discussed a meeting she attended and the importance attached to documentation of this problemlessness.

I typed up the minutes for a CNS meeting and handed them out and gave a copy to the nurse manager … [He] told me some of the information was painted quite negatively. But I said “that’s how it was discussed”. “Yes, but other staff will be reading it so it should be written up in a positive light”. It wasn’t a positive discussion. It was a negative discussion and they tried to make me turn it [a]round into something positive. I spoke to some of the other seniors and they agreed that it was written in the context in which it was discussed. I am not going to change them and fudge them.
The discourse of problemlessness was also evident in Pat’s description of how she, as a nurse manager, believed she gained the respect of a medical consultant.

When I went back to ICU one of the consultants told me they were devastated I was going to be nurse manager. And I said, “Well give me an opportunity”. And within about 3 or 4 months he came to me and told me what a fantastic job I was doing. And the difference was that I learnt really how to manage him … He wanted to know serious problems and facts and potential ways I might have tried to solve it. So whenever he came to see me “Got any problems?”, [I’d say] “no, none”.

Practices of what could be said, how they were said, and what was documented reinforced this subject position. The expectation of being problemlessness led to the silencing of issues that therefore were never raised or documented. For nurses, speaking out about problems in fact led to the identification of them individually as a problem, and was documented in their performance appraisal as such. Glass (1998) has documented the difficulty for nurses to speak out. Leslie described this issue in respect to meetings.

I never let it worry me that [a nurse manager] was there. Another reason why I never got anywhere … I’d pipe up, but what I said wouldn’t be minuted or the strength of it wouldn’t be minuted.

Latu also stated

if I were to speak out, it’s almost like your file – and you said this – and it’s kept.

The managerialist discourse and assumption that a management position was preferable to that of a nurse or clinician also supported the pleaser position. Aspiring to a higher position within the hierarchy was viewed as both a positive and progressive step. Rewards bestowed on staff included additional management tasks such as mentoring a new staff member or supervising groups of new staff, which also reinforced the notion that to manage other staff was a privileged and prestigious position. Val described how he rewarded staff, acknowledging that it was not viewed by all staff as a reward. This reward, he asserted, was to show nurses how they were valued, however, it reinscribed the value of management over that of the nurse.

It’s not all about monetary [things] it’s about being valued … I try and take the experienced group out of the clinical setting every now and again and give them the opportunity to orientate new staff … and people seem to get a bit of a buzz about that. I try and reward them by – I don’t know if it is a reward or not – giving them a group of staff to manage their development. So we have moved on from just the ACN group now, – that some of the CNSs are starting to take on their own group of staff to support and develop.
Subjugated and alternate views—Whistling a different tune

Alternate views questioned the assumption that a management position was preferable to that of a clinical position, however, these were fairly rare. If a nurse chose this, it was deemed that something must be wrong. I initially had difficulty in comprehending the views of Tuin and suspected she must have some secret reason other than her own preference. She discussed in her interview why she was not aspiring to a management position, indicating her awareness that it was not normally what was expected. Tuin had previously held a management position in another hospital.

I felt I would be drawn into the same job again. It was no longer a challenge. That was one reason and also for the time issue. Making a unit work in the initial stages is very very time consuming. You could work 70 hours per week. I want to do social things. Lots of people do say [regarding applying for promotion] "well why haven't you done that".

This alternate position, however, was not easily accepted by staff or management as it did question the assumptions embedded in the dominant discourse. This position of Tuin was supported by actions that she described as necessary for her self-preservation.

"The people I would choose to look after are not the popular patients in any sense. An unpopular patient … a chronic bronchitic … I don’t mind looking after these patients".

When I asked if she thought she was doing almost a trade-off, she responded

Undoubtedly … I was very good at my manager’s job. I think the potential there was for it to run my life … and I am very young and I have got a lot off stuff left I want to do. So now I have to find a way to earn money still doing something I enjoy and am good at whilst getting out now and doing other things I want to do. So yes, it is self-preservation.

Alternate discourses to that of pleaser inherently valued nurses and the work of nursing. Nursing was deemed to be at least equal to, if not more important than, that of management work. The notion of desire was somewhat subdued or subverted if the quest to gain a higher position in the nursing hierarchy was not seen as something to aspire to. Both Tuin and Sam shared this perspective. It is interesting that Sam, who was being chased for a CNS position in another hospital, also noted that despite playing the game, she could see that she would not get what she wanted. Sam desired a better environment and felt game playing, whilst improving her personal position, would not change the environment. This was also in contradiction to how most nurses and nurse managers described playing the game. They viewed it as essential to get on and function within the hospital and to achieve their personal goals within the organisation. Sam described her views.
You know if I had pursued CNS status [in this hospital] I would have got it … but I would have had to play the game – and I still would not have got what I wanted in the end. If I had played the game—if I had promoted management ideas—promoted what was topical at the time—promoted a positive attitude about the unit—not rocked the boat and really roll with that …. [but] that wouldn’t be true to me because I think I should be in an environment where I can suggest things. We have got to create an environment where it is not punitive to actually put a suggestion forward or to try new things.

Leslie described her views of managers as being yes people and not valuing nursing.

It’s probably the reason why nurses are leaving because they’re not managed properly. There is this culture of – the managers who are appointed are “Yes” people and so they just do as they are told and the higher echelons of management don’t really value nurses. If you look at [our manager] she doesn’t value nurses or nursing and that’s appalling … [if] the people at the top aren’t saying how good nursing is and supporting it, why would nurses want to stay in it? They’re the leaders in nursing. Well I think that’s a complete misnomer. They’re not the leaders – they’re the controllers.

Resistance to dominant discourses was often at the expense of individuals, both clinicians and nurse managers. When questioned about how critical care nurses in the unit responded to a manager deferring decisions up the nursing hierarchy and if they attempted to resist or place pressure on the manager, Leslie responded

Well I must say that in the time I have been there we have gone through lots of nurse managers. [The current manager is] the fifth manager since I’ve been there. So we go through them pretty quickly.

This is consistent with studies that identify high turnover rates of nurse managers (Barrett, 1990; Boston & Forman, 1994; Johnstone, 2003; Kippenbrock, 1995; Persson & Thylefors, 1999). However, previous studies have reported that the reason for leaving is often dissatisfaction with support from the organisation rather than pressure from clinical staff.

The subject position of pleaser was predominately informed by patriarchal and managerialist discourses. The notion of desire worked to direct and encourage certain behaviours toward what was constructed to be prestigious, such as promotion. The desire to please involved subtle everyday actions such as not saying no, and the performance of clinical practices according to what was liked or correct in the unit, to more contentious issues of snitching on other staff members. This subject position also entailed exhibiting certain behaviours aligned with a prescribed personality. Self-surveillance and peer appraisals were techniques that contributed to reinscribing this subject position, as well as the identification of individuals
who did not conform being viewed as problems that required corrective developmental courses. Withholding promotion and the notion of problemlessness also directly contributed to silencing alternate views and to specific textualisation of only certain nursing knowledges. Alternate and subjugated discourses included valuing nurses and nursing as being at least equal to the work of management and questioning the lure and desire for promotion into a management position. Most of the alternate views expressed were based upon the previous personal embodied experience of participants and when inclusive of the subjugated views in the previous subject positions encompassed such things as the influence of mothers and previous work roles.

**Being exceptional and elite—*The prima donna***

This subject position describes the nurse whose identity was aligned with attempting or aiming to be exceptional. There was an aspect of being special or elite that was above the often poorly perceived status of being *just a nurse*. Whilst the nurse had few demands outside of their paid working life, they attempted to model exceptional ability and aptitude in their work, and were often scathing of those not living up to this ideal. When requirements outside of paid work increased, a conflict arose with most nurses relinquishing this subject position. The exceptional individual, in an effort to achieve some status, dedicated a huge amount of time to this role. Being special and what was defined as special, however, was informed by patriarchal, managerialist, and modernist discourses that prescribed and reinscribed the identity of the nurse to be aligned with and privilege management and the institution over other identities to which the nurse may have ascribed.

The exceptional nurse was informed by a discourse of elitism that conferred prestige to the individual for being associated with elite work practices and activities. This included the relative status of the hospital, the status of the work unit, the highly complex and technical nature of critical care nursing work, and the relative position held within the unit. In deriving their own personal identity from their work, individual prestige was largely associated with the perceived prestige of the work. This subject position was also based upon what may be deemed expert knowledge, both clinical and managerial with this technical knowledge privileged over emotions, which were not viewed as knowledge.

A few weeks after commencing my study I reflected on the clinical environment.

*This place is crazy. The suffering and trauma is absolute. Every bed is filled with the most desperate attempt to resemble or maintain some likeness to life. The bodies are grotesque, the smell is rancid, and the machinery and noise is everywhere. Perhaps because I have been away from intensive care clinical practice for some time I notice it more now. How do these nurses front up each day to nurse in this unit? How do they deal everyday with the emotions of the relatives? How do they so routinely be the*
bearers of bad news? It reminds me of the elite teams in the armed forces that conduct special missions with high risks. Identified as special, given special training and an elite title, they risk and endure all evils most people would run from. Who really would want to do this work if it was not perceived to be of special status?

In her interview, Chris described how she felt about her current attitude at work.

There [are] high expectations at work and I am a person unfortunately that’s motivated a bit too much I think by guilt. If I haven’t aspirated the nasogastric in the last 4 hours I’ve got to do it, you know. Even though it’s probably one on a scale from one to ten. Someone might come along and say “what’s going on?” So it’s an expectation, it’s part of your work, and you just have to do it. I do [have high expectations of myself] and I feel … like lately I have been very unmotivated and I haven’t gone around as much asking people to give a hand or have been completely thorough as I like to do. I feel really slack, like I’m not doing the job properly … this is terrible … I am still giving good care just not … I just feel like I haven’t done my absolute best even though I know I have done a good job. Also I think it’s from when I was a student here you sort of felt yourself being assessed a little bit like if you sit too long on the chair. Sometimes the ACN comes along and says “You know you could get so-and-so to look after your patient and go and give Bed 1 a hand. “Yes I could, okay I will” … I think there is a general expectation that you give 110% and if you don’t then you are not enthusiastic at work.

Chris further discussed this issue of having high expectations of self, and also of being associated with a unit perceived to be of a high status relative to other units.

You are very much earning your dollar, but then at the same time it gives you real satisfaction because you come away and you know that the care that all of the patients [in the unit] have received is really high care. It is easy to get real snobby about it because you receive the patient from another hospital and this hasn’t been done and this hasn’t been done and you know [in our unit] it would have. So you tend to fall into that – that snobbishness, which is silly … [It] is really hard work because you not only have to look after the patient physically but you are very much expected to coordinate the care … and that is writing down care plans, coordinating, liaising with the family – it is going above and beyond the call of duty. It is visiting them up on the ward and making sure they are getting the care that they needed. Nobody actually says it, but you are very much encouraged to sort of follow them through a little bit …. It’s high expectations.

The critical care course was particularly rigorous and was the training ground in standards and expected behaviour of future critical care staff. The difficulty of the course reflected the
elite nature and prestige of having completed the course. Alex explained her experience and views of the course.

The Honours year I did not find difficult. I used to sit in this group of Masters students who were about 20 years older than me, so I thought, “Oh hang on – all right, I’m [okay]” … but it was a completely different course. You didn’t have to prove yourself with hands on things. I must admit when I started [the critical care course] I’d never struggled in study in my life. I’d gone through school … through nursing … through the Honours year without struggling, and here I came upon the critical care course that I thought “I’m all right – it’ll be all right,” and it was the hardest thing I’ve ever done. All those science/chemistry things it was like, “my God Father”, and not only was it that, I was meeting new people, having to work with new people, having to work in a new environment – it was hell. And people when you start, [they’d] tell you it’s going to be a difficult year but until you actually experience it … and until you actually do it yourself you don’t know what a hardship. People can tell you till they’re blue in the face, “it’s going to be the hardest year of your life” and you think, “Oh yes, I’ll be all right” …. But it’s not till you actually do it that you think, “Yes it was”.

When asked if she thought the course changed her, Alex responded

You’d have to ask the people around me. I know I was a revolting person to live with … because it was so stressful. It’s changed me in the fact that I know what a huge strain I put on myself – how much it took out of me physically and mentally and how much it took out of the people around me. But I wouldn’t do that to myself and I wouldn’t do that to people around me again. So it changed that aspect. I was going to be one of those people who studied, studied, studied. No way. It’s probably sad in a way.

The status or prestige of the hospital was also reflected in how nurses perceived their position. Nurses perceived that this hospital held status with which they then identified. Gaining promotion from a nurse manager to a position such as a CEO or general manager/director of nursing was not necessarily viewed as a positive move if the other hospital held less prestige. Naz described how she felt in respect to this.

I’m quite happy …. Why would I want to be the CEO of some [small] place? Why would I want that? I mean I have a more exciting environment …. I could never be [CEO] here …. This is still a system where, you know, I would probably have to put my time in at a small place. And if I really wanted to be a CEO then I would do it because it would be a stepping stone to what I really wanted. But I don’t really want to be a CEO of a small less complex place, and if I did, I’d want a place like this. So to me it would be a step back to be a CEO …. Some people have actually talked [to me] about
going to [a small hospital] … as being the general manager/director of nursing as a career move. And I think “what the hell am I going to – it’s a nice lovely little … community hospital, terrific”. Now someday I might, when I don’t want the rat race because I can’t do this forever.

The exceptional nurse was also motivated by the notion of having been selected, favoured, or being special. Alex reflected on her promotion.

[The manager] saw that I had some potential and helped me to move along whereas he won’t do that to many people and that does get other people’s backs up … I was one of these people who could quite happily come to work, go home, do nothing else outside of, you know, my patient …. Nearly a year and a half after the course I could see the ACN group had obviously [targeted] me …. Within like 2 weeks I had every ACN come up and say, “Now what are your goals and where do you think you’re going?” It’s a bit flattering in one way to be honest that they saw that you had something to offer …. They gave me a bit of responsibility, and they sort of said, “Well okay, why don’t you think about working towards the CNS?” … I have got people’s backs up [for being] … nurtured in that way because people don’t get that support where I have …. A lot of people comment and say that was the way it was done, and even now there’s someone [else] that people see that they’re nurturing … and everybody compares it …. It’s a hard thing to justify …. Because when I did my CNS application …. I must admit I just came home wrote [up my exemplars of patient care] and put them in with my application …. And yet they wrote back, “Yes, that was fine”. Whereas people working towards them now who I’m showing them [mine], … they are putting in similar things and being told, “No”.

Performing clinical work was not deemed sufficient for the purpose of gaining the esteemed status of a clinical nurse specialist. Doing or giving that bit more to the organisation, particularly the non-clinical bit more was both supported by the discourse of being special and favoured, but also it was reinforced by lack of prestige for failing to perform this. The resultant effect of doing more than just direct patient care duties was that individual identity was then aligned with management rather than with patient care. When I arrived at Alex’s house to do her interview, I interrupted work she had brought home from the unit. Alex explained that she would rather do it at home than sit in an office at work to do it.

The elite status of a clinical nurse specialist was described by Alex, including the contingent requirements of the appointment. Whilst this status was associated by nurses with the achievement and demonstration of certain clinical standards and competencies, the tenuous and arbitrary nature of these standards can be questioned and was not as readily real, fixed, and tangible as how it was often spoken about by nurses.
CNS are really put up there .... People at the moment are trying to become CNS and they are not going to be given that title ... that position ... until they show that they are willing to give that little bit more .... Some people don’t think that they should have to give that little bit more. Part of the exemplars and part of the competencies score is that you contribute to unit based practice ... [and] to research. You’ve got to prove that you are willing to come out of the cubicle and whether that’s right or wrong ... who knows, it’s expected. Some CNS obtained their CNS position a number of years ago. And you cannot turn around and say to them, “You are no longer going to have this CNS position”. And that is a really hard thing that management have to deal with ... letting people that don’t contribute outside the cubicle to continue on in the CNS position. They’ve just brought in a new way of looking at, of critiquing people so to speak. And the aim is that they will be able to weed out these older CNSs – to the point where they are going to depart more faster than we’ve ever seen before .... It’s more looking at the performance management thing and you’ve got to because the job description of a CNS is that you do, do things away from the cubicle and these extra curricular things. And unless people are going to be able to prove that they can, management then think that they can justify by saying, “Well you cannot continue on in this CNS position”.

This subject position was also informed by the patriarchal discourse that paid work was paramount and preeminent to an individual and therefore formed a large part of a nurse’s identity. Part-time work or casual work was viewed as not serious work or secondary to those who were employed full-time and were seen to be normal and seriously committed workers. It was unusual for nurse management positions to be fulfilled on a part-time basis. For females attempting to combine other expectations of their social roles and who had or who chose to have other responsibilities in life, this expectation became extremely difficult, if not impossible. Chris barely questioned what her future role as wife would be, and talked about her concerns of working in the unit when she was married.

It has already impacted upon my work even though I am not married .... I hate to say it, but work is just work at the moment. I still enjoy going there but I’m finding that I am not motivated as much and I feel like I should be doing all these things like putting in my application for CNS and ... all this great stuff, but at the moment I am just not really interested in that. And I feel like I have too many challenges outside of work to take on another challenge at work ... It will be hard to come to work when I am married because I mean there is a lot of changes in store. I will be keeping house for myself and cooking completely for us and you know all those things that I don’t do quite as much here at the moment. And just managing house and managing work and
travelling to work … I think I will probably just go to work and be quite happy to look after my patient for the day and then go home.

Chris further talked about the expectations and difficulties she anticipated and had already encountered between her home life and work life. The expectations at work and the compatibility and distinct division between this and her home life appeared extreme. The type of social functions and inability to participate in this social aspect of work was a definite consideration for Chris. Whilst she was happy to travel a vast distance to work in this prestigious unit, maintaining this travel was also problematic and became a serious consideration. Chris reflected that she would most likely reluctantly relinquish what she perceived to be her prestigious position to work in a unit that she described as being a little bit backwards.

I am very much a person that puts relationships and my family and friends first … Like when it comes to having kids I suppose I won’t have any trouble – cutting back to one or two shifts a week or even none for a couple of years. I feel a lot of expectations from my colleagues to attend all the social events … and I’d really like to because I like hanging out with my colleagues socially, but I just find the distance and the choice of what they do is just – yes – so far removed from what I can do and what I like to do that yes I often don’t go to those things …. It’s just nice to have something outside of work to talk about, and common ground …. It’s the shift work and it’s the distance and now it’s my relationship with [my fiancé] and it’s a whole lot of things …. I’ll probably end up moving hospitals. Because when I was at [another hospital] I used to do a lot of social things with the crowd down there. It was only 10 or 15 minutes for a social function … even though it’s a small unit and a little bit backwards, it’s a good place to work in.

Val talked about his rise to a nurse management position and his experience of nurse managers when he was a student and a clinical nurse. Initially he described himself as being lucky, however, he further qualified his description when speaking of the extant social pressures and gender expectations of male and female nurses. For Val, being a manager was much more socially prestigious than just being a nurse. This elite or favoured position sat in direct opposition to being unvalued, virtually worthless, or dime a dozen.

I was always … lucky I think … I was pretty motivated and … did the right thing and … was a team player so there was never a real time where I had to be disciplined … I [never] ruffled feathers. And the other thing I think was that I was male …. There is no doubt in my eyes that I was given greater opportunities … partly because I was male, but also because I was motivated and played the game …. I don’t think they expected more of girls – I just think that I was a novelty. There wasn’t that many of us around,
so I stood out from the crowd ... whereas the girls, you know ... dime a dozen. There [were] good ones there [were] bad ones .... If I say [to someone in the public that] I am nurse manager of an intensive care unit, I am perceived very differently to being a nurse ... It's quite amazing because ... It's okay to be a male and be a manager of an intensive care big dynamic [unit] ... particularly from males. But if I was a nurse in their eyes, on a ward, wiping bums, I would be a poop and have no career. It's quite – absolutely blatantly obvious ... It's you're a poop and you've got no career path and you know you've got no real prestige about what you do.

The time commitment of nurse managers to their paid work was extraordinary and reflected the patriarchal discourse documented in the literature of an expectation of managers to work long hours, have last minute and late night meetings, and carry home heavy briefcases (Gardiner, 2002). Val described the time and effort he put into his role as nurse manager.

I normally work ... 7 till 6 most days and I do take work home probably most days. I'll do a little bit of reading or something ... I am getting better at realising that if I don't get it done today, it's actually not the end of the world. And I think I'm getting better at explaining to the staff [that] I just can't do everything that they might want me to do on a particular day .... If I can't get their whatever, their pair of gloves or that entitlement they wanted it's not the end of the world – might be tomorrow. So whether again that's that I'm getting burnt out and not being as passionate about putting the things in place – it's that constant dilemma ... whether I'm starting to not be their advocate and doing the things that I need to do. But I don't think I am ... I will always listen and then re-prioritise the things that I think are important on a day-to-day basis. So you know I have a long list to do every day ... and the things that I probably take home are the things I would have liked to get done but probably weren't priorities. So the demands on the family are absolutely enormous ... and it's not that I hate doing it ... it is something that I actually enjoy doing as well.

Naz also talked about her time commitment as a manager and compared this to what she perceived to be a normal balanced life. Whilst Naz was relatively happy with her work role, she described it as abnormal and owned full responsibility for this situation. The modernist discourse of the unitary free agent and the well integrated individual, where work relations fit without conflict, was evident. Naz struggled not only with the patriarchal expectations of being a manger, but also those of being a normal woman.

I don't have demarcations in my life, which is not healthy. And I recognise it but ... I'm the only one who can do anything about that too. So I don't know. I mean I don't sort of say I have to be out of here by 6 because I'm going to a music lesson or a tennis lesson and I don't have children to go home to or somebody to cook for so my things
just sort of roll on … and I can do whatever I want whenever I want because there are no other sort of organised chunks of my life. So it’s not healthy and I’m quite aware of it. I just don’t do much about it …. Overall I think it’s good but I think it’s better to have some balancing factors a bit more. But it’s up to me. Nobody else can do it …. I enjoy it – or even if I don’t enjoy it, or even if I get a little – oh, you know, sometimes. And this is not because of the job, this is because the rest of my life is different and my circumstances are a little different …. I have no family interests because I don’t have kids … you know, the normal things that kids and families do. The normal discussions that come up, the kind of, they go to school, they graduate from university, they have babies …. I have none of that sort of normal things in my life because … I don’t personally have them …. And my relationships are mostly within the field that I work in so I don’t even have many friends outside of even health care, which isn’t great …. If you have an hour to do something it might take an hour. If you have 2 hours it might take 2 … but work spans to fit the time allotted … I have to create them. I have to put them into my schedule. But that’s only something that I can do. So yes, I get tired. I am tired a lot, you know. I’m not too tired … tired isn’t a bad thing … it’s an outcome of something.

This data is consistent with other studies that have documented the extraordinary long hours of work undertaken by nurse managers (Dwore et al., 2000; Robinson-Walker, 1999), the stress and work overload (Fosbinder et al., 1999; Scalzi, 1990) and, for nurse managers, the difficulty or sacrifice of family and social relations (Dunham & Fisher, 1990; Dunham et al., 1991; Dunham et al., 1993; Dunham-Taylor & Klafehn, 1996; Irurita, 1994).

Marginalised and subjugated discourses: Valuing ordinary human qualities, being human, and enjoyment of work performance—Don’t go changing to try and please me … just the way you are

Marginalised and subjugated discourses to this subject position were difficult to detect. Given that the study was conducted both within a critical care unit and in a large hospital, entities historically viewed as elite sites, this was not surprising. Subjugated discourses predominantly involved enjoying and celebrating being ordinary rather than extraordinary. When found they were usually relegated to the tearoom or to personal interviews. Some of these situations were described in the alternate discourses identified in the previous subject positions. Taylor (2000) identified the phenomenon of ordinariness in nursing in respect to celebrating the sharing of ordinary human qualities or being human. Within this study, subjugated discourses additionally related to acknowledging enjoyment of the actual performance of the role, rather than for perceived status or prestige. Acknowledging and articulating human difficulties within this position were also permitted.
Val displayed some ambivalence in his role as a nurse manager and talked of the financial and time penalties he has incurred rather than the specialness of his managerial role. This ambivalence is also evident in the previous description by Naz who described an aspect of enjoyment in her work despite feelings of being abnormal.

There is no way you can sustain this for an extended period of time … it’s just physically so demanding and relationship wise …. My family’s given up a lot for me to come into this role …. To go into this job I have given up family time and money … [I was] getting more than I am now …. The only way I can justify [it] is that, one, I enjoy it so its good for me and, two, hopefully down the track it will open more opportunities up for me.

I was sitting in the tea room writing up my field notes for the day when I realised a few seats away Tuin was individually giving handover on her patient to the afternoon nurse. It was not unusual for the tea room to double up in its use for ward meetings, staff handovers, and any other business that could not be physically conducted within the ward space. I reflected in my field notes

This handover was amazing. I am not sure if Tuin is aware of my presence or if my presence is making any difference to the detail in her handover but I am stunned. The handover is not in respect to the physiological or pharmacological aspects of patient care, but she is handing over detail of the social and emotional aspects of this patient. It is handled in such a detailed and sensitive manner that I am in awe. It is still continuing. She must have talked now for about 15 minutes and no one is particularly impressed or surprised except me who is sitting here absolutely in awe at the everyday work of these nurses.

Managerialist and patriarchal discourses informed this subject position and defined what was deemed to be special or prestigious. Being favoured, a novelty, and being special contributed to this position, such that individuals viewed themselves with status and prestige. The status of the hospital, the unit, and the position of the nurse were also important to the identity and perceived status of the individual. The prestigious position, however, exacted a requirement from individuals that involved going beyond the call of duty, always doing that bit more, performing non-clinical work and, for nurse managers, dedicating extraordinary work hours at the expense of other aspects of their lives. This further reinscribed their identity to management and the organisation. Many nurses were torn between the social expectations of being a normal woman and the roles this involved, together with attempting to fulfil the extraordinary roles that were aligned with being an exceptional nurse. As a result, they articulated feelings of either being abnormal and or of not being able to adequately contribute. A critical care course with exacting and demanding requirements prepared and set the standard for normal entry to the unit. Subjugated discourses were difficult to elicit
and involved valuing sharing and being human that often constituted ordinary nursing work and valuing work for the enjoyment of the work itself.

The expert clinician—The virtuoso
In this role the nurse expected to be respected for their clinical skills and knowledge. This included acknowledgement and consideration of their expert skills and knowledge when interacting with all nurses. Nurses valued and exhibited pride in their own personal nursing practice and their patient care. Other nurses were also valued as colleagues for their skills and knowledge. For expert clinicians their clinical knowledge and skills also included emotive and caring aspects. However, the primary articulated focus was on technical knowledge and displaying professional behaviours such as respect, which was a degree more distant than that of friendship.

In response to being asked about her practice, Latu reflected

I think it was valued by my peers, the other senior staff there, who … I think all valued and respected each others work. But not by management – you were just a number …. I went to say I was leaving – and the response I got sort of proved it … I had heard that he already knew …. There was no talk of what can I do to make you stay and why are you leaving? And what are the problems that I can address? He just said “you will need to give me a letter”. So I pulled it out of my bag. He said “you will need to fill out this form”. I said “well I have been thinking about it for a while but the events of the past few weeks have fastened my decision and I would have liked to have stayed longer” … I had applied for an ACN job and I saw him Thursday morning and he didn’t say anything to me. On Saturday morning my colleagues came up to me and said they were sorry I didn’t get the position – and I had no idea it was written in the communication book that another staff member had got it .... I just think from your nurse manager there should be some form of respect and especially being a senior staff member.

This experience of reluctantly resigning could only be elicited in one other study within the literature (Lanstrom et al., 1989), which was not conducted in an intensive care unit. The data is consistent with the previous study, however, in that nurses reported their distress had not been heeded which resulted in intense emotions of fear, anger, and bitterness. The conflict between the nurse and immediate nurse manager was perceived to be a result of the nurse manager’s hands being tied.

In this role nurses expected that conversations regarding other nurses would involve aspects of clinical judgement or expertise and collegiality, and were reluctant to denigrate other staff
on the basis of personal traits. Latu discussed how, in doing this, she felt she became labelled as non-conforming.

One of the first things that the old manager did when she arrived was to have a meet and greet session with each staff member, which I thought was a very nice and good idea to do. Come into the office and have a five-ten minute chat … [concerning] where you lived, what your social situation was. And then she asked me who my favourite nurses were in the ward. And I said “I am not going to answer that, I don’t think it is an appropriate question. I will tell you who my role models are” …. That didn’t go down well at all …. She had asked the question and obviously everyone had probably answered. And ever since then, we have not got along.

Within the unit the clinical nursing staff were very aware of each other’s expertise and frequently called upon each other to assist with difficult matters. It was recognised that each nurse often had particular strengths of expertise, which were individually recognised and valued. Tuin described how she valued and availed herself of the expertise of other nurses in the unit.

Today I wanted a hand with a wound … I looked around and thought who do I know that is good at wounds … [I looked to find a particular nurse] and said, “what do you reckon?” She said “so and so and so – I’d do that”. I value her opinion otherwise I wouldn’t have asked her …. If she tells me to do something then I’ll take it on board and I’ll do that. And if somebody else wants me to help them, then I’ll help them.

Latu was frequently called to assist in troubleshooting complex equipment where it was deemed that if she could not render it into effect then no one else would be able to. Latu resigned during the period of the study, however, even after she had tendered her resignation she frequently was called upon as the sole person with certain expertise and readily responded. After one incident where Latu effectively set up a ventilation circuit for a patient with a complex respiratory problem that no other nurse on the shift could effect to work, I reflected.

It seems ironic to me, particularly with the shortage of nurses, that Latu is leaving the unit when she also does not want to leave the type of work that she does here. All that skill and expertise she has. It appears important to Latu that she maintains this expert role and her attitude toward clinical staff is collegial and friendly, which directly contrasts with her attitude toward management.

Clinical expertise and expert clinical knowledge provided a source of confidence for nurses in this subject position. Expert knowledge was deemed a legitimate skill and admired and respected among clinicians. Latu recounted how she felt after not gaining a position she had applied for.
I was probably more mad at the time than anything else and I thought well I’ll show you. And I didn’t have any doubt of my own ability at the bedside so, if I was someone who I suppose was a little bit unsure of themselves, I am sure I would have just left in tears and crumbled.

A similar type of confidence was also exhibited by Leslie as she reflected on a disciplinary incident she was involved with.

I had to work all my shifts with [a nurse manager] and I had to do certain other things like go and teach people things and a whole lot of extra stuff …. Bearing in mind I was [a] senior member of staff, so I still had heavy patients …. I thought this is crazy – we don’t do this to people who are poor practitioners and they are supervising my practice. MY PRACTICE is better than their practice … I thought this is ridiculous – so I went to the ANF … and we got that halted.

In this subject position numerous nurses noted that their clinical expertise was valued poorly. According to Sam, the low pay reinforced the poor value and worth attached to the clinical nurse.

It goes back to the whole reward and remuneration [issue] … To say “just a nurse” because for 20 years you stayed clinically focused. You’re still a nurse – you are not a consultant. You are not charging a fee for your service … you are not anywhere better on the pay scale. So that is reinforcing that you are only worthy of $20 an hour after 20 years of service.

Whilst adopting this subject position, nurses judged other nurses and nurse managers according to their clinical expertise and skills. Tuin recounted her thought on the role of a unit manager.

I have never seen him with a pair of gloves on. And I think that's a poor show … I expect to see my manager out here to see what’s going on. Because I don’t know how you can make decisions about what your work load is – what your staff are feeling – what's really going on in the unit if you don’t know what is going on because you never get out of your office …. I wouldn’t be able to tell you whether my nurse manager was a good clinician or not.

Chris also talked about the importance of the manager having good clinical skills and knowledge, however, her interpretation of the manager differed from that of Tuin. Whilst Chris’ interpretation of nurse managers was more positive than Tuin’s description, she also however described the activity of one nurse manager as that of no longer nursing.
I like it when [the manager] comes out when we are really busy and takes over for an hour and showers a patient … takes his tie off and puts on a plastic apron and away he goes. That’s really impressive that he can go to meetings, talk with all the big wigs but also put on his rubber boots and go shower a patient …. He understands us out on the floor so that’s really good …. It should never be handed over to non-nurses … [inclusive of] all the way … up to the DON …. Sometimes unfortunately those people are so far removed from the clinical scene that they have forgotten a little bit what it’s like …. [One nurse manager] is so far removed and expects us to be like she was back in her days of nursing …. It’s a bit different now.

In this subject position nurses demonstrated pride, worth, and enjoyment of their clinical work. Clinicians had difficulty in articulating this and tended to describe what they enjoyed in terms of the special critical care aspects of their practice. Latu reflected upon her practice following her resignation.

I did like the work. I like the busyness – the fastness – fast pace and nursing the sick patients that you get in there. Yes, and I wanted to learn and I did enjoy it.

Similarly, Pat described her desire to look after patients despite her role as a nurse manager that limited her ability to perform clinical nursing care. She raised the issue of expertise and noted the requirement for continual practice for which she did not have time.

I really miss that part of it … I keep wanting to … still look after patients. And there is no doubt I could quite happily go in and look after a stable ventilated patient without any worry if I did it tomorrow. But I need to be able to keep doing it and I am struggling to fit it in now. And that’s really what – I like doing. It’s a reality check – it makes you stop and think what you are doing and why you’re here. And I think we should do it more often.

The issue of maintaining clinical expertise for nurse managers was difficult, and it appeared that nurse managers were pulled between two competing positions or identities. Throughout my time within the clinical environment I could not identify any mechanisms to assist or support nurse managers to keep their clinical expertise. I reflected

Nurse managers, whilst expected to have clinical expertise, are expected to be orientated toward an interest in improving their knowledge of management only. From the absolute silence on this subject, I gain the impression that if this topic was raised as a problem it may have been construed that they either had too much time or had their priorities wrong.

Alex, who had recently moved into a nurse manager position, described the difficulty of staying in clinical practice and displayed her concern yet indicated a type of positive
progressive inevitability in respect to how nursing had changed. She clearly articulated what she believed were the relational benefits of being present and doing nursing with other staff.

[The unit manager’s role] has changed dramatically ... as much as they try, they are completely removed from the bedside and a lot more managerial ... [like] running a business. Personally [that] is hard for me to get my head around, because I was so used to ... they were in handover, knew the names of the patients and they seemed to know their staff very well ... But now ... not that there is anything wrong with it, because I know that’s the way nursing has changed but they are very much a manager with the emphasis on manager rather than nurse .... Three quarters of their time is off at meetings and managing budgets and things like that. So far as actually managing the personnel and managing the [clinical role] I think that’s gone .... The ACNs take the role of maybe what the nurse manager did .... The ACN role is [also] changing a lot ... [with] more responsibilities away from the patient and [nurses] ... such as project work, research [and rosters] ... I still find it difficult to justify sitting in an office and doing the roster when you’ve got nurses out there nursing as such .... Probably because I’m not the sort of person that can sit down for long .... To me I’m there at work to do ... to look after patients and be there as a resource for staff ... I couldn’t justify sitting there doing projects, even if everyone was sitting down doing nothing, which is really stupid .... Maybe its part of me wants to know exactly what is going on ... the certain steps where staff are at ... [like] their personal life does to a huge extent affect what they are doing at work .... You do get a feel when you are out there actually working with them ... Although people say don’t bring you personal life to work you can’t help but interact with people ... It’s a subtle way of saying you know, “Is everything okay?”

Val also talked of how he missed clinical practice and how it was essential for his role as a nurse manager.

It’s amazing how quickly you lose your skills ... I certainly see that when I do go back into the setting, and I love that patient contact ... You’re not the person who gets thanked immediately from the family and your name’s not normally on the card, ... but you certainly probably helped .... You have to infer that, and from this position you infer it even further .... I love to close a door and do a [complex] dressing and let the world go away .... So I absolutely – I miss the practice. So it’s important that I be out there ... to maintain my own spirits ... that I’m not losing touch ... [and] that people still see that I am clinically competent. That I’m not just speaking as a manager, I’m speaking as a clinician.
Leslie commented on her experience as a clinician.

There was a group of us who were very concerned about standards and we wanted to do an audit of nursing care and [the nurse manager] blocked that because he felt that it was too threatening … [Managers] say they [value good clinical practice] but in practice they give no sign of it …. We would always be complaining that the standards were dropping and things weren’t being done … [but] there was just no support …. So good excellent clinical skills are not rewarded or appreciated at all … [The manager] introduced these fluffy … nurses’ recognition awards … but again it wasn’t necessarily for clinical expertise.

This subject position was predominantly informed by the subjugated discourse of valuing clinical nursing practice and skills. There were few practices that reinscribed or rewarded this subject position. Whilst many managers did talk of the value of clinical knowledge and practice, little time was dedicated or prioritised to its accomplishment. Clinical skills were assumed to be accomplished and the focus and priority was for gaining the more privileged knowledge of management. Both clinicians and nurse managers in this subject position spoke of their enjoyment of doing nursing, including the busyness and fast pace, getting feedback from relatives, the reality check or reason for being there, and for keeping up their spirits. This supports the findings of Westmoreland (1993) who, in researching the identity of nurse managers, identified that the direct giving of patient care by nurse managers was a means of connecting with oneself and as a grounding technique, such that being a nurse was a major dimension of nurse manager identity.

The emotional human—*Resonating from the heart*

In this subject position nurses overtly displayed their emotions. At times, emotions were freely exhibited, however, this position appeared to be only adopted when the impetus for the display of emotion was overwhelming. Nurses exhibited a visible range of emotions including fear, hurt, concern, anger, happiness, disgust, and sadness. They also acknowledged they themselves and others had emotional requirements. This subject position was predominantly evident only in individual interviews with nurses where self-doubt, a low sense of self-worth and lack of confidence were often simultaneously exhibited. On return of their interviews, many participants indicated they had not been asked about themselves before and thanked me for the opportunity to speak about issues and to debrief. On many occasions when nurses adopted this subject position it was in relation to taking on the suffering of patients and relatives. Often they described their emotional needs were not recognised by managers. Some nurses also described a sense of deep hurt in direct relation to their treatment from or working relationships with nurse managers.
Latu requested an exit interview following her resignation. She described this exit interview with a nurse manager to me.

She sat there at the table like this and there was a window there and she looked straight out the window most of the time. She didn’t look at me – answered the phone a couple of times … And I thought why am I here? She is not interested in what I have to say …. When she answered the phone for the 3rd time I said, “Obviously you are very busy, I will just go” and she said, “Oh yes – and thank you for coming to see me, that was good”. And I just looked at her and put out my hand and said, “Well I hope that you have heard what I was saying. Thank you for listening to me” and left.

Latu also described how she felt since she has resigned.

I feel lost more than anything else. You know the patients [where I now work] are really sick but they are no where as sick … and it’s not that I am bored … I just feel a bit lost. I don’t know where I am going. Like I have stepped off with all this busyness and now I am lost – lost.

Many nurses appeared to have their status and identity tied to this critical care unit and the nursing work of this unit. Resigning and moving from the unit was a difficult step and required an overwhelming impetus as the emotional result from a feeling of loss of status and achievement was also not easy. The strong emotional response and hurt that is experienced by individuals as a result of being part of the nursing turnover has been described by Landstrom et al. (1989), however within that study the relationship of the emotional hurt to the status or identity of the nurse was not explored. Sam also described her feelings of having resigned.

You know I paid for that course. I wanted to do that course and committed myself to doing it … I like what I do in crit care – I enjoy it … and it has taken me quite a while to actually say – to come to terms with I have left …. It is only recently I have said to people that I work [elsewhere] … I was embarrassed to say. I thought I had dropped out – that I was suddenly – was not an achiever … I don’t like it. I feel like I have dropped out and I don’t like that feeling. Downsized myself.

Nurse managers also suffered feelings of frustration and feelings of inadequacy, although these were related to different aspects of their work. When observing nurse managers, I frequently almost ran alongside them to keep up as they moved from one meeting to another. They usually described what the next meeting was about and who would be in attendance as I attempted to negotiate running up stairwells and down corridors. Pat described how she felt in coping with her work.
I am meeting people from anywhere from 7.30 in the morning until 6 at night and I do not have a break for lunch .... You only have a stop to go to the toilet and you are late for meetings because one meeting finishes and you have to travel to the next meeting .... Then somewhere ... you've got to fit in the massive amount of reading which I cannot get through and so I never feel I do things to justice. And then you've got to do the work for it. Unless you've done the reading you can't really do the work. So I sometimes feel like I am ... “flying by the seat of [my] pants” .... We are about to take on another 16 hours of meetings [per month] in our new role ... and so something is going to have to give. And I think what would be beneficial for me. I am not saying it is going to be good for me, but it would be good for the position – is that I need to come in on one day in the weekend, ... get through some of the work and sort of start afresh. At the moment I feel like I’m sinking in a number of different work and not doing any of them well.

I commented to Pat that the situation must detrimentally effect how she felt about herself and she agreed. The requirements of the position, however, were of equal or greater importance to her own emotional requirements and intrinsically linked to her own identity as a nurse manager.

Emotions of happiness were also experienced which could be more clearly shown. Naz described such an experience as a result of her interaction with another staff member at a meeting.

We were sitting there and there was a young guy [male nurse] there. We were talking about what nurses do. Minute little sorts of things. What is it that the nurse does and what is the nursing bit really? And he said, “Oh I never thought of that”. I said, “Good, that’s a new challenge” .... He had told his mother [about me] because his mother’s a nurse. [He said] “I told her you know she’s not a matron.” And I guess to me that’s still – I just love it. I just love ... I love having people think ‘Wow. I never thought. Yes, maybe or yes’. And I do absolutely love it. Yes I do I absolutely love it. And I felt ... you know, I felt ‘Oh God’, and I came racing back .... It just felt really good, you know. And I felt much better after, at the end of that than I did.

In their interviews, participants related experiencing fear in their work environment, however, this was not overtly displayed in the clinical environment. It did perhaps explain why the lack of participation in the medical round was barely challenged by nurses, as it was just the tip of the iceberg in respect to their subordinate position within the unit. Chris described an incident that occurred to her when she first commenced working in ICU and how she and others continued to handle working with this situation.
It was something that happened out of the blue .... He, the consultant, just got extremely angry at me and was basically yelling at me and he almost hit me he was that angry. And the nurse in charge immediately stepped in, intervened and basically told him to go and sit in a room by himself and made sure that I was okay .... The next day the unit manager called me into his office and sat me down and just said, “Now are you okay about what happened yesterday – want to talk about it?” Told me the action that had been taken ... an interview with the consultant – that he had written a letter to the medical manager explaining the situation. I was very impressed by that because I felt like he cared enough about me as a person that he took time out to call me into his office, debrief, tell me what action he’d taken .... I did feel somewhat in danger to think that [the consultant] was that angry .... [He still works here] and apparently it has happened before ... and it does still happen from time to time ... [Now] I am very different with him .... It sort of gets passed along from cubicle to cubicle that he’s in that particular mood and not to push his buttons. ... So I just – I don’t say anything else outside what I actually have to say, and I say it in as non-confronting manner as possible.

Even in an interview situation nurses often apologised or attempted to explain away their emotional feelings. They described their emotions as being unusual, of attempting to hide them, attributed their display to being a problem of their own personality, or to being female. Almost all participants prefaced their description or embedded within their description an explanation of themselves as being individually unusual or different for having or showing these emotions. Latu described her experience of a time when she cried openly in the unit.

[I] felt quite drained after this patient died ... and at the end when they left I just sat back and said “I am going to cry. I am sorry” – I cried, just cried. And then one of the older ACNs came in and made fun of me with some smart comment. I said, “the day when I stop caring is the day when I leave the job”. “Oh” he said, “I am used to it” .... “Because I am sitting here crying this is my relief and that’s okay. And I don’t have a problem with it and why should you”. But I guess he is from that thinking that you don’t do that .... That is how it is, that’s hard. Perhaps also because he [is] male, and therefore unable to show his feelings, relief, emotions, etc.

Nurses were often deemed not to be a source of knowledge of their own emotional requirements and these requirements, if articulated, were frequently not heeded. A department perceived to hold authoritative expertise, however, could make recommendations regarding the emotional needs of staff that were not so readily ignored. Fineman (1994) identified rationalism, masculinism, and the marginalisation of emotions in discourses of organisation that suppress, deny, or minimise the role of emotions. A harsh split between
what people feel and what they can show they feel results. The death of young patients was often emotionally traumatic and Latu described one such death where she felt she was expected not to publicly show her emotions.

Sometimes the patients do get to you and others don’t … but that’s me anyway …. I had a young 16 year old boy that died …. He had a shadow – a big lump on his chest x-ray – he came in with respiratory failure … and pretty much cried all night because he thought he had cancer and didn't want to die. And this boy was in and out of ICU over a 6 month period and I got to know him and his family very well …. He ended up dying. And it was tragic. I went to the funeral. It was “oh we will have to replace you on the roster ....” I said “I need to go, I want to go ....” The nurse manager wasn’t all that sympathetic until we had a debriefing with a member of human resources who suggested going to the funeral as a means of closure. Then she became quite sympathetic and was quite eager to do the roster swaps …. I had to work another day on my day off to pay for it …. Just before he died – when he slipped into a coma – his family were in and I knew his family terribly well …. I was just so upset …. [A consultant] went and got my coat from the tea room – took me to the back door and said he wanted me to go away for half and hour. A couple of days later he called me into his office and said “I have never seen you before like that”. He was amazed …. It was almost like that sort of natural emotion was not for public display. [The relatives] keep in contact …. They visit the grave every day. They still can’t accept their loss and I have no idea how I would either if I had a 16-year-old boy. Sometimes it is still a bit empty – [I] still think about it.

Nurse practices of allocating patients was often performed with little regard to the emotional needs of the nurse, but instead was performed according to how the nurse in charge deemed they could best utilise the available staff resources. The effect was that nurses often felt a huge pressure to endure issues and not show their emotional requirements. Chris, who had been almost hit by a medical consultant, recounted her experience with the allocation of patients.

I’m not one to really hide my emotions very well so usually the more astute ACNs can tell if I am having a bit of a rough time. Yes they’ll just come in and say “Look I think you really need a break now” or “go sit in the tea room for a while and have a coffee” …. I am starting to learn a bit more when I am getting to that stage where I am getting very overwhelmed … like not wanting to go to work and thinking about calling in sick …. Three or four weeks ago I looked after a patient who was physically aggressive and actually hit me one day …. I found that after that day it was almost impossible to look after him just because we really clashed personality-wise …. The next day I came in and they had allocated me to work in there and I just said to them “Listen, I just
can’t go in there today.” She said, “that’s fine no problem”. And then the next day she said “Would you like to go in there again?” And I did go in there because I felt I was back to working in there but I just didn’t cope at all on that shift …. I think she felt like … because I’d had a day’s break I was ready to go back in. And I thought I was as well and then I sort of went in, mentally – geared up to go in there and … after about two hours in said, “No, I can’t do this … I can’t come back in here at all.”

The physical violence, bullying, and abuse suffered by nurses has more recently been documented (Cox, 2001; Farrell, 1999; Farrell & Bobrowski, 2003; Glass, 2003a, 2003b; Hegney et al., 2003; Jackson et al., 2002; Randle, 2003), including that managers often accept and support this work culture and are also often implicated in this violence.

The economic efficiency of the institution requiring staff to attend and work designated and budgeted shifts was rarely questioned by nurses, nor the responsibility of the institution to individual nurses for their exposure to the development of close relationships with patients and relatives. It was perceived that a good nurse could be both emotionally receptive to patients and family, and simultaneously be technically and functionally proficient. Whilst being receptive to patient’s and family’s emotional situations, their own conduct should not display an overt show of their own emotions. Alex displayed this requirement in her rather harsh description of other staff. Staff must be functional and this requirement was prioritised over nurses’ emotional needs. The issue was transferred to become a problem of the nurse and was not seen as a problem of the system. The economic requirement of staffing and shifts moved nurses to and from the bedside, as well as in and out of management roles. Alex talked about her own emotional difficulty in being separated from relatives with whom she had developed a strong relationship.

I worked 10 days recently and looked after [a sick] boy for 8 days taking on all that the … emotional load …. It was his wife that I had all the dealings with … and then on days 9 and 10 [I had a management role] … and I can’t be there …. And the wife was sort of following me down the passageway … and I did try to explain to her how it works but it really …. To them it looks like you couldn’t give a hoot. You walked away from her husband …. Why aren’t you looking after my husband? …. She knew at the beginning I was on for 10 [days] and then I had 5 off. And she said, “… you have to come in”. Puts a bit on to you – although you know deep down you need your days off because you’d be useless to her and to the patient anyway …. And that’s why nurses are still there at 10 o’clock some nights and at 5 o’clock after an early shift. It’s sometimes really hard to separate yourself …. Sometimes [senior staff] have to step in …. And people you know fight to go on and on and on. But sometimes you need to recognise that the best thing people can do is to get out of there. And you need to help
them recognise that. A lot of ICU people do it and once one or two people start doing it everyone feels like they have to do it. If people stay till 4 o’clock and come in on their days off .... “Oh maybe I should be doing that too.”

Chris talked about how she handled her emotional needs. Informal mechanisms plus the sensing or knowledge of other nurses appeared to be her main supports.

Sometimes we have debriefing sessions if there has been like two or three patients die in a week and even particularly tragic or difficult deaths. I don’t find the formal debriefing extremely helpful .... Sometimes I pull our social worker aside and have a little chat to her .... A formal debriefing occurs in the tearoom and [it is led] and it’s supposed to be an open discussion. But there is usually 10 or 20 people in there so it’s big …and I don’t find people are particularly open with you and it’s hard to be open yourself if you feel other people aren’t … [The manager] is usually pretty open like he’s actually cried in one of the meetings which sort of surprised me because I didn’t realise he was so emotionally attached to the family of a particular patient …. But – I don’t think people really express their feelings that well in that sort of debriefing session. And some people would rather not reflect on it and just move on. Whereas … I really like to reflect on it and debrief … I do that a lot more informally … [for example] if you are sitting in the hallway .. especially on night shift or in the tea room just with a couple of people and you happen just to mention “Oh it’s just really sad what’s happened in cubicle 6 and you know the family is really devastated …. So we sit down and chat about it for a few minutes. Or else, I have a good friend in the wards … I express it to the person in charge as well .. and often they can sort of sense that I am feeling that way and usually they’ll say, “How are you going?” … “How are you holding up?”

Nurses were expected to be empathetic and compassionate to the emotional needs of relatives and patients on a daily basis, and yet simultaneously control and not display their own humanness or emotional response. Emotions were predominantly to be boxed and released only outside the unit in a controlled manner so that the nurse could remain functional. Blocking out or becoming impenetrable to emotional concerns was a technique nurses employed in order to achieve this functional composure that was perceived to be a behaviour of a nurse who was both coping and strong. Alex spoke about the difficulty of withholding emotions and the pressure to not become too emotionally involved with patients or relatives.

It is a very fine line between showing that compassion and remaining a nurse. You can’t break down every day at work. That’s the hard thing to do .... Having to hold all that emotion in all day can be so exhausting, and I think that really is the reason for a
lot of us … [for not] staying in nursing …. Part of it [is burnout] because you can’t show your emotion …. Three or four weeks ago [I looked after] a young boy … and I had his wife every day in tears. I cried and I mean I quite openly told her that not everyone would do that but that’s just me when someone cries like that. But I had to quickly turn around and function again because I was there to care for him, and if I’m there a blubbering mess it won’t be fair I can’t [function] … You do need to hold it in to a certain extent. You do need to sort of turn around and get on with it, and to a certain extent I had to block out what she was really saying because I couldn’t handle that. Here was a girl my age losing her husband saying all these things that she wanted to … and so trying to support the patient and trying to support her – you couldn’t do it. … [Another hospital] had a [relative support] role … It’s been suggested that something like that needs to come into our [unit] …. But for some reason … [costs] it doesn’t look like it’s going to. I was looking after a patient going back 18 months ago. He was a young boy once again and he … [died] in the end quite unexpectedly … it was horrific … And it was something that I will remember forever …. Having to go out and tell the family that he had passed away. It was actually [the manager] who said, “the people involved … need follow-up support” … And it was the most productive couple of hours I think that I have ever experienced from a situation like that. But it’s not something that’s encouraged. People [don’t always want it] but there again they’re strong enough and they can cope.

When I asked if it was a sign of weakness if you couldn’t cope, Alex responded

Yes, yes and I came back and I quite openly said to everyone how beneficial it was … I was hoping it would sort of start something but it hasn’t. There needs to be a lot [more of it]. This patient had been with us for 2 months. You get to know the family at such a vulnerable stage that you probably get to know them better than people that you have known for 20 or 30 years …. This patient wasn’t expected to die …. So having to go out with a consultant to tell a wife, a mother, a sister, a brother that their brother had died. And his family just wailed and wailed and they were all lying on the floor and being physically ill …. Then having to go in with them to say goodbye to him it was horrific …. There are certain patients, or certain families that you really warm to … This patient being just around sort of my age. It really sort of touches you a bit. And they were such a warm open family that it is very hard not to become … And although you say you are not to become involved, you do.

The hidden nature and public perception of the work of nurses contributed to the emotional difficulties of nurses. Jo talked about her emotional issues that arose from her work and the difficulty she experienced of finding people who really understood the experience.
It does affect you a lot. I bring [the emotions] home … I’m the type of person like I come home and I don’t realise that I’ve bought them home up until a couple of weeks down the track where I notice I’m a little stressed out. Exercises like playing tennis, going to the gym … that can help me at times and trying to socialise with my friends. It just builds up with me until I really hated going into work … [my partner is overseas] so he hasn’t been here …. We talk it out by phone. He’s very good, he’ll sort of just let me talk …. It’s also hard because he doesn’t work in that area and he doesn’t truly understand what we face each day …. My best friend is a nurse so we sort of talk to each other about things. And also … people at work, talk to them as well. Like [my partner’s] good you know … I can hear him saying “I can’t really like picture it in my own mind” … but he’ll try and understand how difficult it is.

This subject position was a marginal position and nurses struggled to articulate their concerns, often utilising apologetic tones. The institutional requirements for economic efficiency and the patriarchal discourse that privileged functionality over emotions as a sign of strength resulted in nurses attempting to cope and to blame themselves for their feelings. It was paramount that they remained functional. Nurses were expected to be able to box in their emotions and to block out emotional issues, whilst simultaneously emotionally supporting and entering into extremely deep relations with patients and relatives. Whilst many of the emotional issues related to the direct or indirect care of patients, nurses also displayed strong emotions of hurt as a result of their relationships with nurse managers. This is reciprocated when clinical nurses clinically and socially excluded and isolated an individual due to their position as a nurse manager within the organisation. The lack of emotional support for nurses has been described in the literature that is consistent with a view of organising that suppresses, denies, and minimises the role of emotions (Fineman, 1994; Held, 1993; Mumby & Putman, 1992; Pringle, 1988; Tancred-Sheriff, 1990).

**The personal improver and coach—The maestro**

In this role the nurse coached other nurses, usually of a lower position than themselves, in the nursing hierarchy with the stated intent to improve and progress another individual. Individuals were perceived to be amenable to improvement in respect to their personal and professional development. This usually involved the acquisition of further knowledge, skill, and experience. By assisting nurses to progress or by providing this opportunity for nurses to develop, they were then potentially positioned to further advance their career. This modernist notion of progress however, similar to the notion of being special was defined and informed by instrumental and patriarchal discourses that therefore also determined the direction of this improvement. Coaching behaviours were deemed an essential part of leadership and
therefore expected of anyone with a management role. The ability to contest being *developed* or specific alternative discourses could not be elicited.

Coaching, guiding, teaching, mentoring, and developing were deemed positive behaviours and were instigated with enthusiasm. No-one could be over coached or have too much development. Pat clearly demonstrated this subject position, as it was a passion of hers.

> Developing people … I love it. Sitting down having a conversation – watching them develop, getting skills. I like reading about different ways – different theories that are coming out.

Val described his role as a nurse manager in which he also clearly articulated a position of coaching and developing staff. He also indicated a process he had commenced to assist this staff development.

> I see it as absolutely supporting staff in regards to their career development, making sure that they are comfortable with their practice – finding out if there’s anything that’s worrying them, but trying to be available to help them get wherever they want to be …. If I can, try to help facilitate their development – I see that as my role …. I really enjoy that support and development aspect …. Every week I look at who I haven’t met for a period of time … and I slot those people into my diary. We have also created a structure where the ACNs help facilitate that by taking a group of staff. They continue to follow on with [what is started].

This subject position was informed by a discourse that personal improvement was not only desirable but also required. The act of *being* was not sufficient and the individual should attempt to improve themselves. This is consistent with modernist discourses of progress and improvement. It assumes that the individual requires guidance or else is lost. Nurses also played out the notion that the act of *being* was insufficient, which I found when I first commenced *being* in the clinical area.

> *Most participants want to know what I want them to do. What specific acts do I want to observe them perform? They will then oblige. To be themselves and to do what they normally do seems insufficient. I think they would feel more comfortable if I said ‘please stand on your head’.*

Val described the type of guidance that was required for nurses and also what he thought nurses expected from him. He related the *being* of a nurse to be perceived as inadequate by both nurses and himself.

> I don’t think nursing has had very good performance development programs or appraisal processes …. We haven’t been really honest with the feedback that we give. I think a lot of times we fall into traps to maybe just elevate the feedback that we give.
... and that we don’t actually give people real guidance about where they can develop. We will just talk about the nice things and forget about the nasties .... I try and really make sure that I give people some constructive goals. This is where I see you really need to work, so that they see that I really do know them – that I really do value the good stuff that they do. But also [what] I think they really need to work on – so that it gives them a bit of a motivation – a bit of a career plan ... maybe develop further instead of getting stale or “where do I go now? Yes, aimless you know. I see nurses in our environment ... they’ll do the course ... [and] 12 or 18 months post that ... [they’ll say] I am starting to get bored. If you just say “Your doing really, well keep up the good work” they go out and say “where in the hell do I go now?”

Guidance and development however was also systematised into a complex process or technology involving the collection and documentation of data pertaining to staff, the frequent and regular monitoring of staff, the documentation of performance goals, and the monitoring of progress toward these goals. Peer review processes, career plans, performance development plans, ACN staff groups, and leadership group discussions all constituted part of this complex and formalised technology. This technology was evident in Val’s description of one staff member’s concern with lack of feedback.

I put a process in place to support and then develop them, but if they don’t know that I know they’re doing a good job – the loops not closed .... Now we facilitate part of the peer review to have manager’s comments as well .... A student recently [said] “I haven’t had much feedback from you of late” .... Our database has said that she has had feedback about every second week from either the ACNs or the clinical teachers, but when we got down to it she hadn’t had it directly from me .... The feedback was coming from our fortnightly leadership group discussions … and then the ACNs would go back with this feedback … [but] she wanted to hear it from me. So it is hard work and I try and see every staff member at least six monthly … I keep a record of who I’m due to sort of see .... The staff appreciate that. I think they feel valued. I think they know that I know where they’re at and that I have some involvement in their development.

Coaching was aligned with notions of developing and improving nurses, rather than notions of changing with its less favourable connotations. This subject position was also supported by and supported the subject position of junior novice (or playing second fiddle) by providing the senior partner (first fiddle or maestro) for potential nurse manager relationships. It was further supported and reinscribed by the subject position of pleaser, with nurses seeking direct approval from those whom they perceived to be important to please. Coaching and developing staff was also systematised so that rewards accrued to those who
met certain guidelines which were developed to measure the performance of individuals against the meeting of standards. Standards and guidelines had the effect of directing or normalising behaviour, which was directly reinscribed by rewards such as gaining a perceived prestigious CNS position. Val explained about the guidelines utilised within the unit.

The guidelines help ... I give it to the person and say, “Do you think you meet these criteria?” So I put the challenge back onto them. “And if you think you do then bring it into me and we will discuss it”. So they’ve got to say, “Well yes, I think I do”. Hopefully by me talking to them frequently enough they will already know whether they are meeting the standard ... [and] keeping them up to date with whether they’re meeting your expectations or not .... At times you have got people that don’t agree with the expectations you set or absolutely have got no insight into it. And they’re always the tough ones. But ... I think you’ve got to be really consistent, because as soon as you reward someone that everybody knows isn’t performing then the reward is lost.

Developing and coaching staff was perceived to be a positive act and nurses were fortunate to have this assistance. This subject position was aligned with growing, challenging, valuing, and rewarding. Rewarding clinicians with management responsibilities, such as the supervision and development of other staff, was described in the subject position of pleaser, however, it also reinscribed this subject position of coach. Valuing and rewarding staff was shaped by instrumental and managerialist discourses to the extent that rewards were for progress or achievement and usually also of benefit to the organisation. Alternate ways of displaying to staff how they were valued were limited. Val explained this by describing a distinct lack of control or autonomy in his position.

In regards to reward, what can we do, very little. It’s really about recognising their achievements .... I try and just give them opportunities to do things that they might want to do .... We had a whole heap of people present for a recent conference ... I gave them a whole heap of time to prepare for it. And then on the day I gave them the time to go ... through the [rostering] which is something I absolutely control and no-one can take it away from me. And they don’t even know what I do with it .... [The] time ... is cost neutral for us, so it’s not like I have to worry about the budget .... So it’s one thing that I can do to just value the staff .... Other ways ... [are] in our latest newsletter I have done a big spiel about how people presented and how well they did. And then I have organised photos for the hospital newsletter. So just little things – hopefully it makes a difference.

The coaching position was usually conducted with the most serious intent to assist and support nurses. However, the almost zealousness with which it was often performed
appeared at times to override any obvious consideration of valuing staff. I reflected upon this issue at the end of a shift after a small party had been held in the tea room at double staff time to farewell a staff member.

The manager appears to interact well with the staff and looks to be trying to be one of the team. I feel the manager is trying to impress upon me his concern for staff. He seems to be trying to emphasise this to me, yet staff are joking of his unusual behaviour—i.e. cleaning up the mess after the party—and he is not enjoying the joke. Perhaps he feels concern for staff is an area that requires further work. His behaviour is not consistent in that he does not check with staff that they agree to my presence prior to talking privately with them—I have to interrupt to check. I felt embarrassed again today to witness a meeting between the manager and a nurse regarding her performance. The nurse had to argue that her confidence and therefore performance had improved. This level of conversation should not ensue for a grown mature woman. There seemed to be no recognition of the huge responsibility she was taking being in charge of the whole unit—and I think anyone would be a little unconfident in taking on such responsibility. The manager gave some positive feedback but seemed patronising. He talked of learning objectives and journalling. I wonder if the manager journals. There seems to be some dilemma for this manager in how he values and develops staff.

In this subject position, coaching and developing other staff were considered attributes of a good leader. Naz viewed the development of others as a key aspect of what is required in a leader. She described a person who she believed to be a good leader and the qualities required to lead.

She’s real down to earth – she’s a person who connects with other people. Directly connects with people. Really effective leaders are never the arrogant blowhards that everybody thinks are leaders. People sometimes think .. mistake that for leadership .. A really good teacher and a good leader [is] an educator at heart. Attitudes, behaviour and the development of others that is to me what leadership is about. It’s got nothing to do with power and authority. It’s about attitude, vision and the development of others .. The most effective people I ever saw focused on having a vision, developing others, and focussing on managers and behaviour.

Coaching and the development of relationships with staff were linked by Naz. She described her frustration with traditional views of management that have little emphasis on relationship building and her challenge of a male in a more senior position than herself who held this traditional view.

A lot of management people believe you move on every 3 or 4 years .. I think you have to stay in a place to make a difference .. These are people who think they can move into a complex organisation, they can whip around and make some
assessments, they can reorganise, put in their structure, change the organisational chart and letterhead and everything else and then they move on to someplace else. .... You don't build something in a year. ... I had this conversation with [the CEO]. That was his view .... I said, "no sorry".

When asked if she had been tutoring him, Naz responded

Maybe. Possibly – I think it's challenging those ideas. Talking to people about what really makes a difference and sending them articles and saying, "Look what this person says. What do you think about this?" I do it. I read something the other day and I sent it to him. "By the way, I just read this. People join organisations and they leave managers." I believe that I think that's true. It's about the culture. People might come here because of the reputation but when they leave its often about the way they are treated. All those little things that add up.

The subject position of developer or coach was heavily informed by modernist discourses. Growing, challenging, and improving staff to achieve rather than to be was necessary as staff required improvement and guidance. Managerialist concepts constructed the need for staff to be developed, how they were developed, and what constituted a reward. A complex technology of knowledge was generated regarding the development of staff and systematically monitored and documented their progress. In this position it appeared that nurse managers often had a very serious intent to develop relationships with and to assist nurses, however, managerialist discourses prevailed and they displayed their value of staff by rewarding their progress of development. Nursing literature has also portrayed this managerialist and positivistic discourse with staff development, guidance, and coaching viewed as both necessary and progressive.

**The keeper of order and appearance—*Sounding the tone***

In this position nurses acted to ensure that events and the environment were perceived by others to be well planned, controlled, and in particular to ensure it was seen to be in relative order and harmonious.

Being present or having presence was an issue that arose strongly in this position. It was evident having a presence was important to nurse managers and that this was perceived to demonstrate their confidence and right to be within a spatial area. It also afforded them the opportunity to interact with staff. This was a difficulty for nurse managers, given the large number of staff and time constraints. Clinical nurses also raised the issue of not seeing nurse managers which they felt indicated little interest in themselves and the clinical environment. However, when some nurse managers (usually without critical care skills) did enter the clinical environment, the tension to politely tolerate their presence was clear. In this subject
position nurses participated in overt actions of keeping order but also in the setting and monitoring of behaviour, as well as the promulgation and dissemination of information to nurses to challenge thinking and therefore construct or reconstruct another individual’s understanding. Giving meaning and having a vision, which are deemed skills or attributes of leaders, was important within this subject position.

Overt actions of keeping order for nurse managers were to deal with untoward behaviour of nurses. Naz described her perspective on dealing with inappropriate behaviour of nurses.

Today I had a discussion … [about] a nurse that I coached the manager through. And there will be another meeting tomorrow …. The behaviour of the person, the nurse, is absolutely unacceptable. Intimidating, belittling, all those sorts of – the horizontal violence sort of stuff, bullying, whatever you want to call it. It’s absolutely alive and well … but unless you know how to deal with it, it will continue. This person’s been in the organisation for 10 or 15 years, and this is not the first time. They haven’t all of a sudden had a mental breakdown, you know. It’s been like this forever and people have never known how to deal with it. I’m very comfortable. I have no worries. We will go right in there. It might take 6 months but I tell you – The manager said, “But this is hard.” I said, “It’s very hard but it’s harder not to do it … even if we have to spend an hour a day, you know, sort of dealing with this person … going through the union and going through the lawyers”. And her saying, “I didn’t say it” … and “How can you prove that I did this?”… And it will ultimately happen. And then she will probably go on stress leave and everything else. There are 30 nurses who work with that person. If we don’t do this, it’s not fair to them.

Nurse managers were aware that many clinical nurses did not perceive their role to be important. Pat discussed the issue of clinical nurses’ attitudes toward nurse managers.

I think they label me as admin. and that’s a difficulty that I have. And part of it’s [because I am] not there present … An important thing is attending forums and talking with clinical nurses so that they do understand that I understand some of the issues that they face … and I think they would wonder what I did with my time … I have to be mindful that … It’s actually the nurse manager’s job to do that discussion with staff. I can do it when it gets really tough and I am happy to do it then – but the reason why I like doing it and like to be present there is actually to develop the relationship with those nurses so that they do see … that there is some substance to my role.

The keeping of order also included spatial order. Who frequented or felt comfortable to occupy different spatial areas also gave some indication of the relationships and rules of order between individuals. Pat described her presence in ICU.
I went into this role with the idealistic view that I was going to change perceptions and of course it is always harder than you always imagine it to be, but I don’t think I have given up yet. And I know the new ICU is more my home than it will be to many of the other nurses and so I think my presence there – I will actually be more comfortable there than any of them. So it will be very comfortable for me to wander around that environment right from the start …. We are going to have daily meetings when we first move in so that we can fix any of the little problems …. I think they will at least know who I am.

During my time in the clinical area I often positioned myself to sit on a stool in the cubicle where the nurse who I was shadowing was working. This way we could talk, I could keep watch on the patient, and I could easily alight to help with things such as patient lifts, washes, and being the temporary portable intravenous stand. It also kept me from getting in the way. Whilst sitting on such a stool late one evening I reflected.

Nurse managers, other than the unit manager, are rarely seen in the unit and then it is usually only on an evening shift to walk the row of beds and briefly chat to some of the nurses regarding their patients. I wonder if I will be questioned as to whom I am or what I am doing as most, I guess, would not be familiar with me or aware of my research. Instead they smile and nod so either I am fitting in pretty well or they really are just smiling and nodding to all.

Toward the end of my time in the clinical area, I made a further reflection.

Today at the unit meeting a senior nurse manager attended. This has been the only time I have seen this nurse manager in the unit. Only 5 staff attended in addition to myself. It was fairly obvious that staff did not want to attend and they did little to hide their movement as they squeezed out the door or withdrew themselves from the tearoom once they saw what was planned for the meeting. The unit manager was also present and was trying to encourage people to attend. The senior nurse manager did almost all the talking whilst staff sat fairly mute and listened. A few staff made short comments or asked polite questions toward the end, but the tone was pretty flat.

The issue of contesting expertise was raised by Jo who described her experience of nursing supervisors.

They come around once a shift to see how things are going but there is only a few of them that are critically care trained …. They don’t really have a very good idea about the needs and of what’s going on in ICU. Like I sort of make comments and, “Oh.” Some of them are really good and others come and go and say, “Oh is everything okay?” I think they know that they really don’t know the ins and outs of ICU. For instance like when I was in charge … on night duty and there was a patient that was to … come down to ICU …. And the ADON was really pushing, pushing, pushing to get
this patient down .... I said, “I’m not bringing them down – like you’ve got an anaestheticist up there for the patient. We’ve got no one to look after them down here, it’s not safe ... we’re waiting for someone to come in and things [are] going on at the moment.”. The next night she, the ADON, came down saying that wasn’t good enough .... And she clearly hadn't understood the situation down in ICU and what we were dealing with at that time and that it was unsafe.

Various practices within the hospital also assisted to ensure that order was kept. Numerous types of meetings were regularly held, one type being a unit managers’ meeting which consisted of nurse unit managers plus one or two other senior nurse managers. An agenda was set by these more senior nurse managers, who also chaired the meeting. I attended several of these meetings and reflected.

This meeting is almost a social occasion with wine and nibbles. Everyone chats away about their respective unit and they appear quite relieved to be out of it for a while. The meeting does appear to serve several purposes. The unit managers get to chat, debrief, and exchange ideas however the exchange occurs in the presence of the more senior managers who control the agenda. Unit managers each take a turn to speak about a problem in their respective unit. It is almost like they have to have a problem and a competition as to who can have the worst problem. Problems range from staff harassment to staff ‘shooting up’ and ethical issues. The ICU unit manager does pretty well with a technical description of a dying patient having received a fairly exotic drug that potentially contained blood products when they were ethically opposed to this. And should they be told. The unit managers’ attitude or method of managing the problem is the central focus with most unit managers very eager to please the more senior nurse managers who act in a coaching role. Unit managers describe how they have, with great difficulty, successfully managed the problem. The meeting provides a very good forum for senior nurse managers to keep abreast of information and to monitor unit manager issues. Simultaneously they effectively set the tone for unit managers to articulate their success as managers within this group and create some competition within it to also reflect this tone.

Emotional outbreaks of unit managers were carefully handled by more senior nurse managers. I did not witness any of these occasions during my time in the clinical field, but heard that they had occurred. They did not transpire in the formal meetings but usually took place in a private office. Pat described her perception of what she felt nurse managers often wanted from her and what she could provide for them.

What they want is someone to listen to and offload so that they can do it in a controlled environment. I’m not going to think they are having a nervous breakdown. They can go back to their ward feeling that they have got something off their chest or that they are trying to address things.
This informal practice of keeping emotions private also served several other functions. Unit managers could be somewhat pacified as they simultaneously traded their confessional for some emotional support. Hierarchical reporting mechanisms ensured that untoward incidents or issues were noted and monitored and appropriate actions could be instigated. Unit managers met and reported to senior nurse managers on a regular basis. Senior nurse managers reported to the most senior nurse also on a regular basis.

The subject position of keeping order also involved unit managers monitoring and keeping order within their respective units. The practice of meetings again assisted in this accomplishment. Val talked about his requirement to ensure staff within the unit realised they were only part of the larger hospital and therefore their needs had to be considered alongside other needs and subordinated to the larger needs of the hospital.

You’ve got to have that broad [hospital] view … that ICU isn’t an entity to itself. It fits within a bigger scheme of things and trying to help facilitate that to our staff.

Facilitating or selling hospital and political directives to staff was also part of Val’s job and essential in attempting to appease potential conflict. This notion of nurse managers having the role of selling a concept or new organisational policy to staff that they themselves had no input into has been documented in the literature (Manfredi, 1996, Wong, 1998). Manfredi summated this as “consequently their visions for the future are a function of the organization” (1996, p. 312). Everson-Bates (1992), in an ethnographic study, described the role of the first-line nurse manager as the arbiter of social reality. This issue is seen in this study where Val described the issue of opening an extra bed.

[A politician] stands up in Parliament on a Monday afternoon to say [we are] opening a bed on Wednesday – and I’ve got no staff. Well – as if we’re going to say, “We can’t do it” … The [hospital] didn’t even know about it …. Can we then go back to them and say, “Well sorry, we’re not doing it because [the unit manager] says he can’t get staff? …. So how do I then sell that to my staff who already feel the stress of the work budget we’ve got? Knowing that we’re not going to be easily able to get staff and replacement – because we’re not getting a budget for it …. It did eventually [follow through with money] …. So, you know – I’ve got no control over that …. So how do I sell that in a way that I’m looking after their needs but I can’t stop it? … You have to sell it in a way that … okay, I know it’s going to be tough, but our EFT is good at the moment. We’ve got a great group of nursebank …. I’m going to have an agency contract – we are going to get consistent staff. I’m going to get the best agency – the ones we already know. I’m going to put them on night duty. So trying to come up with the way to sell it to them that it’s not going to be as impacting. I’ve committed that we
are going to [increase the number of beds] in ICU and reduce the step-down – another carrot for them. It didn’t work out but that’s how we sold it initially.

The practice of meetings was essential for keeping order so that a large amount of staff could be communicated with at one time. Managers had several specific functions to achieve in these meetings. The predominant functions were to diffuse tension, appease staff, and persuade staff to feel their concerns were understood. Val talked of this and his feeling of being the meat in the sandwich.

[The staff] don’t understand the broader issues that maybe a nursing manager has to deal with and that ‘meat in the sandwich’ stuff, and so it can create some tension. I think the challenge is how the nurse manager copes with that, to try and alleviate that tension … [and] how good the nurse manager is at achieving …. But [the staff] don’t understand the constraints that are placed on me that I can’t do the impossible with the resources that I’ve got. And, you know, ICU isn’t the most important thing. And there’s not an endless supply of money … I’ve got to try and make sure that I’m hearing them and listening to them and showing them enough that I do care and that I do see their points and that I am trying …. Hopefully with constant communication and how we communicate things and one-to-one feedback they feel appreciated, do understand the dilemmas that we’ve got and it gives them an opportunity to voice their concerns …. They mightn’t necessarily agree with me, but at least they understand that I’ve heard it.

Promulgating and disseminating views to challenge thinking and existing understandings also assisted in keeping order. Naz described her role in having discussions with staff and needing to connect with their understanding in order to alter their way of thinking and to gain trust. Messages needed to be expressed and repeated frequently, and in different formats, in order for this to be achieved.

Historically we haven’t been open and we haven’t had the kinds of discussions with people that we tend to have now … You also have to learn how to do that because some of the managers themselves get pretty defensive when the staff come at them … I think our job is to not only be able to do it well, but I think the reason I try to do it is because I want [other] managers to learn how to do it too. Every single time I do it … [I’m thinking] it might give a manager … a way to express something that is difficult … because it doesn’t matter that I say – it has to be repeated over and over again and pretty soon people will come to understand that I am telling them the truth. There isn’t anything hidden …. If they get to trust that and see it often enough and it seems transparent then they won’t keep saying, “But you didn’t tell us”. My euphemism is, “Here I go … plug in tape number 26 and out it comes” … and I’ve got loads of them
and I say them over and over and over again. [I think] did I hit the mark with this group?… I don’t think I turned anybody around, you know, so I’ll have to do it again.

The notion of nursing leaders as being sense-makers, giving meaning to complexity, and reducing ambiguity and uncertainty for followers, has recently been advocated by Villiers (2004). This art of managing meaning was promised to offer a rich rewarding and stable environment for nurses. The promulgation of views within this study occurred predominantly in forums and meetings. Naz further explained this issue, indicating that staff attendance and participation was often not high.

This is going to sound contradictory to what I said earlier but I actually do love to tell some of these stories and to challenge people’s thinking and to see them sort of rise to the challenge and get it. I had an open forum with the staff yesterday … and so anybody could come. Now not a lot of people came, it’s a pretty difficult time … I’m going to a ward next week to just go to an afternoon tea when they are all there …. Sometimes in a big group they don’t ask questions because they don’t know the other people [and] … they don’t want to be seen to be silly.

Smaller meetings with specific management staff also occurred at a unit level. Alex argued these meetings played an important role, which resonated with her desire to clinically work with staff in order to know them personally.

There is a very important role for us in a management meeting …. The people that are applying for their CNS are spoken about in quite detail. Not their personal things … but more of what they are like out there in the ward and how they function …. Because [non-management staff] are not allowed in there [to these meetings], they get their back up with it. And when … people know that you are talking about things like that … it is frowned upon. But I’ll argue that there is a position for it … because you only work your 4 or 5 days a week and you only work your 8 or 10 hour shifts you don’t know what happens the other … [days and] the other hours you’re not there. And sometimes, especially when you only work with someone say once a week or something, it really is hard to get a feel of where they’re at and what they’re doing …. As long as it’s done without malice and it’s not just a big personal attack. I think there really is an important role for it.

The systematic documentation or textualisation of information in respect to staff again assisted in attempting to keep order. This was linked to meetings. As well as unit manager documentation of staff appraisals, performance plans, and the unit management meetings, ACNs also had a system of meeting and documenting staff behaviour and performance. This was described by Alex who, utilising a patriarchal discourse, attributed the lack of trust amongst staff with this system to nurses being a bunch of gossiping females.
The ACNs do have this database system ... It's not to know what staff did last night, but things that are going to impact on work. Its popped on the computer and the ACNs have access ... [It] can be a very difficult thing because some things are obviously said confidentially and there have been complaints ... But if you actually see that it is impacting on their work, it is very difficult to ignore the fact that you have been told that that is going on .... Personally I think [my responsibility] lies with the individual and if I'm going to put something on database ... [it is the] issue and not the circumstances unless the person has said [put it on] ... But [non-management staff] don't get a chance to read it. They don't know what it's all about. They see it as one big group session ... like the management group. The door gets shut, the blinds go down and people see that as a group of staff sitting around and bitching about staff. It is, to some degree, but it's not the whole point of it. There have been a few issues there where people said they don't want [issues disclosed] or whether ... they just presumed it wouldn't be common knowledge, and they have later found out it had become common knowledge. And that's a huge problem ... It sounds almost derogatory to think of nurses as being a bunch of females, they like to gossip. But as a whole they do – they really do. And it intrigues me how much people know about people and want to know about people .... I think we do it in [a negative way] ... you can't hide much for long .... I think that happens to a larger degree in hospitals but I also think it goes on outside of it too.

Maintaining order also required that modernist and dominant instrumental patriarchal discourses were upheld. In articulating these discourses, nurses directly reinscribed this position they adopted in maintaining order. Most nurse managers articulated they had little conflict between their personal beliefs and performing the work required of them in the organisation. Likewise, gender was rarely raised except as being an issue of the past, with the present system described as having markedly progressed from the past. This is expressed by Naz in her interview when I asked about gender issues.

But in terms of gender being an obstacle to any sort of advancement or progress, I've never felt that was the case .... People thought that a lot of the 'C' words, commitment, caring, conciliation, communication, those sorts of words that are often associated with women, would come into the workplace and humanise the workplace a bit more. That didn't happen. Because in the early days the women who made it in the man's world had to be more vicious than the man in order to compete. You had to be twice as good sort of thing ... There was a lot of rhetoric about the compassion but we were pretty rugged to each other. And I don't think we grew up in an environment that was supportive and developmental. I think it was punitive .... There was a lot of humiliation and ... at the time people were terrorised. So I don't think it's a female
thing ... I think it's always more about power and the perceptions in organisations of power and in egos.

Keeping order involved being diligent over a very tight budget, although this was initially only indirectly evident and not overtly stated until the later part of most conversations. Budgetary restraints were a problem and yet not a problem, according to what position the nurse was adopting. Early in his interview, Val spoke about his accountability for budgetary matters.

Even though nursing isn't really budget focused, we do take a little bit more accountability in regards to management of budgets and resources than medicine. Even though I'm not absolutely budget focused, I realise my accountability there and perhaps we are more wary of that.

Later in his interview, Val adopted a different position that openly criticised the current situation.

A little bit more budget would make a big difference ... we're scrounging from the bottom of the barrel at the moment .... We're not meeting the budget ... we are blowing it every year, so I haven't got enough now. But if I could have an extra bit to do what I thought was appropriate each 12 months, that would be fantastic. Whether it's for rewarding people, giving people study leave, doing research projects ... creating a new role. But it wasn't attached to something specifically ... and that you had the scope to ... that you weren't being locked in ... Whereas, you know, the public hospital system is so tight. Every cent's accounted for too and most of it's absolute bedside nursing.

Marginalised and subjugated discourses—Questioning the score

Subjugated or marginal discourses to this position were very rare. Silence and lack of participation may have indicated resistance perhaps more than overtly articulating problems, as described above by Val. Asking questions and raising the issue of political action were two techniques of resistance, rather than discourses that I could elicit. Dissatisfaction with input into decisions and the power of nurses to invoke political action was mentioned by Chris.

There has been a lot of communication about what we think and what we liked ... although I don't know how much of our suggestions actually get used in the end. We often get told that this is the way it is going to run or this is the way it is and what do you think about it. So it's almost too late ... In a way [the manager] is like trying to make us feel better by saying "What do you think and let me know how you feel?" ... but not that he can do anything about it .... A lot of people came to him and said that
[they would leave] .... I felt sorry for him because his hands were basically tied and when he did come up with a solution he got wrapped on the knuckles. So its crazy .... I don’t think we have really much to do with big decisions ... which is a shame because I think nursing has a lot of power. But we are too busy or too something to actually band together as a big force .... Big political action – yes, which we could do. We would have the power to do but, yes – most people probably wouldn’t do that.

Those who asked questions threatened to disrupt the perception of order. Leslie described her experience.

There was sort of a group of us that had the same sort of approach who would question things. [The manager] was saying how one day I made her feel dreadful .... It was just about ward round time and we don’t usually have patients’ visitors during ward rounds and she said "so-and-so’s visitor is here ... could she bring him in?" and I said, "why?" She felt bad the way I questioned her .... I tried to explain that when I question I am questioning rationale, not necessarily being threatening. I’m not questioning their authority or their decision making process, I just want to know why ... that’s why I question things at ward rounds wherever ... I have an inquiring mind.

This subject position constructed and maintained the order of the status quo. Nurses who construed their management role was to give vision, meaning, and to challenge the views of other nurses, frequently adopted this position. A systematised technology of formal and informal meetings and documentation supported this subject position and textualised specific knowledges about nurses. This then informed the rather distant nurse and nurse manager relations. The seemingly democratic we effect of meetings has been described by Deetz (1992b), who also found that meetings defined the subject by public ritual. Being present and promulgating views was an important part of this role in giving meaning and understanding to issues and in challenging other views. As such, it involved participating in the ongoing construction of reality, including how others perceived it. Articulating the dominant discourses that informed this position was important so that the position reinscribed itself. Spatial order, however, was contested and indicated some tension or resistance that may have also been present in the form of silences and lack of participation, raising questions, and the thought of political action.

The strategist—Simply irresistible

In this subject position, nurses quite openly articulated that they strategised in order to achieve goals. Power was acknowledged, including how individuals either positioned themselves or felt positioned in respect to issues of power. Predominantly nurse managers indicated that they strategised. Talking of strategising as a purposeful act entailed in itself the
use of modernist and managerialist discourses such that these discourses primarily informed this position, however, other more marginalised discourses were also evident. Individuals adopting this position often contested a particular view and associated thinking in order to be able to achieve an objective, and their movement between discourses was swift. A high level of skill in artful articulation was evident.

The very need to strategise, rather than to rely on existing social mechanisms and supports, indicated a lack of power in itself. This, however, stood in direct contradiction to other dominant discourses of good managers or leaders based on the assumption that a good leader or manager is strong, effective, and successful. From this perspective strategising was therefore acceptable only as long as the outcome was positive, strong, and effective. This position, similar to the valorised stories of nurse managers in the literature (Jeska, 1994; Schorr & Zimmerman, 1988; Scutt, 1992; Smith, 2002), when described by nurse managers and informed by the dominant discourse of leadership therefore displayed a tendency toward articulating the strength and effectiveness of the nurse. The circumstances, however, in which strategising took place often belied this. Whilst nurses openly shared their experiences, I believe they had difficulty in moving between the dominant discourse that gave assurances of power that was held and the subjugated discourse that talked of the difficulty in achieving power with. Put simply, it was the contradiction between articulating the expected dominant leadership skills of being all powerful and articulating either a different notion of power or the very lack of power. The difficulty, complexity, and extent to which individuals within this position strategised indicated the precariousness of nurses in this subject position. Notions of power did vary. The more subjugated power to or power with rather than power over (Lind et al., 1986; Spitzer, 1997), was evident on occasions. It appeared that demonstrating allegiance to powerful people within the organisation was essential in order to be trusted and therefore to have the ability or power to do things. Power over other nurses was expected and therefore essential to ensure that this allegiance stood.

One nurse manager clearly stated her view in respect to dealing with the subordination of nurses by medicine. Other nurse managers also adopted this position. This contentious view may be attributed to the poor position of power and fast turnover of senior nurse managers within hospitals and the dominant instrumental and patriarchal discourses pervading the organisation. Some nurse managers also had many years of experience, which I suspect contributed to the adoption of this position. Naz reflected.

I guess I’ve been in this business long enough … I accept I don’t rail against things that are just there. Yes, the medical people have much more power in the system than we do. Well, so what? What am I going to do about that? … But quite frankly why just yell about it … It’s just a waste of energy and we should be saying, what arguments
ought we be making? To whom should we appeal? How can we be effective? … I’m not uncomfortable. I don’t think I’m straddling. I don’t think I’m not ambitious. I just think I’m somewhat realistic …. If I decided that I wanted to do something about lack of parity in salaries not just in health care but anywhere then I’d have to get politically active to do that … [but] you don’t have enough energy to do that plus do your job … I [have] said to nurses, “I will never ever, ever, ever go to any table in this hospital and fight for something on the basis that we deserve to have an equal way, because I don’t believe that.” I think we have to be relevant and I think you have to make yourself indispensable for the delivery of care in this hospital. And I will work very hard to make sure we are indispensable. But head to head with the doctors, we’ll lose. And I don’t even want to play that game. I will not do it.

Naz was very clear on this issue and further elaborated.

This has always been the way the game has been played … and [clinical nurses don’t understand] … That’s why I’ve said to them over and over again, “I will never ever, ever, ever, play the game like that. And if you want a [nurse manager] like that you haven’t got one. But we’ll try to build something here that I think we can achieve. But you’ll go down in flames more than you’ll win in that battle so I’m not interested.” I’d rather take all of that energy and do something that we can all be very proud of and we can achieve and people can feel good about it. So I will never, ever, ever, do it, never … and nursing doesn’t have a power base beyond my position so …

I commented to Naz that this put a lot of pressure on her. She responded passionately.

But you can’t change that. You can only do what you can do as an individual. Recognise that that’s the way it is and that’s because it’s been [like that] for a hundred years … Yes it’s awful but what am I going to do about it? It’s once again, where do you want to waste, spend your time … I don’t know whether we have to get better at being like that or they have to change their paradigm about how they ought to work in the future. And I think both will happen. I think nurses can get more savvy … if we start being more subtle and strategic and being more effective in the jobs that we’re in. And simultaneously that some of the people in medicine do believe that they can actually contribute. And it’s not so personal and it’s not about egos and we change the paradigm a little bit. But we’re talking about cultural societal changes that I’ll be long dead before they happen …. Do I want to be frustrated every day of my life because of that. No, I just want to figure out how I can do my job because … I can’t change it … Really I am working in my own way professionally. But on a day-to-day basis I need to sort of figure out how … and I can only control how I respond. I can’t control the politics of who got elected government … all I can control is how I respond to it. So that’s what I try to do.
The strategist position conceded on some issues they believed they had no influence over and therefore limited their attention to what they believed they could influence. This is consistent with discourses on resilience in management training. Literature has documented this as a recommended technique to reduce stress for females working in a male dominated environment (Gardiner, 2002). Naz reflected on her ability to make changes.

I wish we had better collaborative relationships with the medical staff ... more decentralisation of decision making. That there’s more collaborative decision-making sometimes .... But there is nothing I can do about that .... So I need to figure out what I can do that gives me a lot of satisfaction and develops people.

The development of relationships in order to gain respect and trust was an essential aspect of this strategist position. Pat described her relationship as a nurse manager with a medical co-director.

I have just been away on a retreat. My whole goal was on developing a relationship with him and I was very fortunate. I was the only one there, only nursing [manager] where the medical counterpart was actually there for the whole workshop .... Both of us know that he only works one day a week and I work 5 days a week and who’s going to be doing all the work. But I think what we did develop is develop a bit of respect for each other and that was outstanding.

Irrespective of the goals of a strategist however, the methods, techniques, and actions often reflected non-dominant discourses as well as dominant discourses. For Naz, being strategic also involved developing relationships and gaining the respect of others. This relationship development was different to networking which she viewed as being an ego issue. Being a nurse Naz did not have the powerful network of influential colleagues that medical professionals did. Naz commented on her style of working and aligned networking or name-dropping with being domineering. She articulated her style to be different from many of the attributes commonly contiguous within patriarchal discourses and masculinised management styles, which she clearly indicated her dislike of.

I won’t do it in a confrontational way [or by] pounding on the table and demanding that I be heard. I will do it through gaining people’s respect, by making comments. I suppose strategically, by demonstrating I can deliver what I promise on things. And those are the things that I think people ultimately respect and I’d much rather have that sort of a working relationship with people than just being able to placate them and having a better network. I think being able to drop a name, you know it doesn’t interest me at all and I probably wouldn’t do a very good job at it because I wouldn’t work hard enough at it to just be domineering. I certainly have an opinion and I wouldn’t say that
I shrink from a challenge at all. But I don't think I’m confrontational and I don’t think I’m adversarial.

Thinking things through, seeking opportunities, and engaging in the opportunity to articulate views was essential in the ability to strategise. This articulation could be in the form of subtle suggestion, however, it was directed to achieve specific goals or to reverse thoughts on a particular issue. Collinson (1994) advocated that the disciplinary shaping and conformity of individual identity and subjectivity may be resisted by persistence, which is often more effective than distancing and involves having a greater involvement in the organisation and negotiation in determining meaning. Naz reflected.

I process a lot, I talk things over, I mull things over. I frequently go to people and say … the phrase that I always use is, “I was reflecting on our conversation yesterday and you know, could we talk a little bit about it because there is something that ….” And it's usually because I know exactly what I want to say, and I know exactly what I didn’t like about it yesterday, but what I sort of do is try to, “You know I was thinking about it and something occurred to me … had you thought about this, or had you thought about that, or what would you think about it if? What would you think about the outcome if it turned out to be something like this?” That's the way I think I am … I talk a lot. I formulate my ideas as I’m talking.

Naz further elaborated that in strategising the achievement of the goal was more important than her personal recognition.

Some people network because it’s quite visible and they want to be seen to be driving things. I couldn’t care less who drives them [or] whether anybody even remembers that I had the conversation with them the night before if in fact the next morning what comes out is what I want for the outcome. I don’t care who thought of it. I don’t care if they say, “Gee you know I was dreaming about something last night and I think we ought to do this”. I couldn’t care less even if it’s my idea.

Gaining the acceptance of ideas and simultaneously not being recognised for directing a decision was often also intentionally strategised. Pat described a process she normally utilised for this with clinical staff and the stress it caused her when she had to implement something quickly and did not have time to implement her process that covered the fact that she was directing the idea. Her difficulty arose from having little control over time or decisions.

Sometimes when I am dealing with people who are so resistant to change and you don’t have time for them to be resistant … when their whole thought process is bureaucratic and trying to get them to move forward in a short time frame. Normally …
if I am in a ward and I get people to come to terms with a new idea and we talk about it and ... then gradually people will decide we will trial it ... It's nice and cruisey and then you can implement it ... [but] when you ... have this tight time frame ... we have got to implement this thing starting next week. How are we going to come up with this idea?

Challenging assumptions, raising issues as crises, suggesting alternate views, seeking alliances, and having discussions before meetings were part of the strategist position. Dwore et al. (2000) reported nurse managers as working with political games such as pre-meetings to circumvent exclusion where meetings followed the male ethos of announcing a decision rather than making a decision. Naz talked of her efforts to alleviate a problem.

I said, “This is a whole state-wide crisis nationally and internationally. We might have to make some concessions about how we make decisions about [this problem rather than] the way we've always .. [done it which was] .. based on an historical set of assumptions .... That's one set of assumptions that will lead you down one path. Now I'll give you another”. ... Two people have said, “I think that's good.” I said, “Good. So when we have this discussion .. I'm going to push this discussion next week and between now and then you think about it and if you've got any questions before then you come and talk to me about it. Then we will have the discussion beforehand.” So again that's the way I do it.

Maintaining clinical skills and being in the clinical environment was a strategy for many nurse managers. In other subject positions this had been articulated as a desire. For nurse managers, keeping their clinical credibility was essential for challenging practice, particularly if their role was closely associated with the clinical area. Val described this need and how he challenged practice.

It's important ... that I [am] out there ... [and] that people see that I am clinically competent ... that I'm not just speaking as a manager, I'm speaking as a clinician .... Keep up with the latest things that might have been instigated. It also gives me a little bit of opportunity to challenge practice. I can say “Oh we put them onto pressure control. Why have we done that?” ... and they see that I am a clinical thinker. Even the conversation that we had at the ward meeting today where it was about ceasing treatment ... that we've got this perception that patients, that once they're terminated there is bed pressure to have them die. It's pretty huge ... I just sort of talked about my – our expectations and from my perspective a terminal patient that is now in a palliative care stage is not an ICU patient. We don't need to get that patient out to take a new admission. We've got spare cubicles .... That patient can be one to eight nursed if we really want .... There shouldn't be any pressure that we can't take that
other admission. How can I have that conversation if I don't understand the processes that are involved? ... Otherwise I go in there ... and I get asked one question and they'll say, “He didn't know what he was bloody talking about” … so you've got to understand the practice to be able to challenge it.

The strategist position also carefully utilised opportunities, being aware of the influence of suggestions and their particular timing. Informal relations and interactions were again, like the pre-meeting meetings, just as significant as the formal interactions. Naz reflected on the depth of knowledge she has acquired and her almost intuitive approach.

I constantly walk into [my boss'] office … I know his work patterns … when to interrupt him [and] when not to … when I can get his attention and when I can’t … I’m very aware when people are here and when they’re not, how they work, when I can tap into them or not, when I should drop the hint or, “By the way I would like to have”. Like last night [my boss] was leaving at 8 and I was still here, … so I went in there … [and] said, “I just wanted to tell you something and I won’t keep you” because I knew he wanted to go home. So I said two or three sentences to him, and this morning there was an email. And I didn’t ask him to do anything … but I just dropped the seed and I said, “I want you to think about this … what do you think would be the outcome if we did something like this?” … I never have agendas. I never sort of organise things. I’m much more I think opportunistic and process.

Marginalised and subjugated discourses—Thinking, listening, reflecting on complexity, and rethinking

Subjugated discourses were also evident and enabled the strategist to articulate their concerns with dominant discourses. These, however, often were not to the complete exclusion of dominant discourses. An awareness of complexity and how reductionist type thinking or tools can influence perceptions also informed this position. Naz indicated that she selected to use at times reductionist flavour of the month tools, however, she did not believe that they could provide all the answers or understandings of situations possible. This varied from dominant discourses informed by economic rationalism, privileging linear thinking, reductionism, and quantification.

The K.P.Is are the absolute flavour of the month, and of course I contribute to them and I think they’re important … but all they are, are another tool that you use to try to help you to understand things. But you cannot reduce the complexity of the kind of work that we do to a series of 25 dot points … I do believe there is plenty of room for … reducing as much variation as possible. But I think it will never be like an automobile factory. And people who come out of that sort of mind-set … [that] there must be an explanation for everything. You must be able to pay more attention to the
process and therefore get more – less variation. You can do all of those things to a
degree, but you cannot have simple answers to complex problems.

Toward the end of my time in the clinical environment, I reflected on my own strategies of
being in the clinical field.

I anguish at the thought of how I am going to write up all that I have seen and felt.
How am I going to give voice to the perspectives and experiences of these nurses
without putting my opinion as the only one that counts? I also know, however, that I
am often viewing things quite differently and I suspect that it is due to my privileged
position of having read widely and spending the time to focus so intensely. These
nurses have been so open, have freely given of their time and thoughts and have
provided or enabled me access to meetings and places from which I would otherwise
have been excluded. For all this effort of trying to ‘fit in’ I am the one who is doing the
study and I feel somewhat of a ‘robber’ that I have taken without giving. Group work
would have been a disaster with the dynamics between these participants so I am
pleased I did not try this. Fewer participants and much, much, much more time would
have enabled me to develop closer relationships, but then would that be only to
influence my opinion onto these nurses?

Strategising often involved issues in respect to budgets and the control of money. Notions of
budgets and monetary problems were articulated by Naz quite differently to how Val
described his budget.

I never think money is a constraint … I never worry about money …. You hear people
bleat on and on about [the lack] … of funding you get so it’s impossible to get good
outcomes. Well I never even believe that … Sure there are challenges but I think
again that’s blaming the system … I like to see what people have tried to do and
where the blockages were and how innovative and creative they have been before
they go saying it’s not possible …. If you don’t have a realistic budget you need to just
be telling people … we’re over budget for these reasons. My view is that we can either
do this, this, and this or close beds. What do you think we ought to do? Well I know
[my boss] is never going to say close beds so we’re not going to….

Later in her interview, Naz reflected

I get frustrated of course because [medical staff] … I mean there would be groups
around here every once in a while who beat their chests and demand all sorts of
things and get the million dollars worth of equipment … I suppose I could have beaten
my chest … but let’s face it, it’s not going to happen.

When I asked Naz why this wouldn’t happen for her, she responded
They do it … by saying they are going to withdraw their services. I would never do it …
so they’d get it …. I think that’s reprehensible and I’m a team player and I don’t think
that's the way you work in organisations. … [However] there would be groups of medical staff who would do that … threaten [to withdraw their services] and whether they actually would who knows. But we never call their bluff on it and if I wanted to be the C.E.O. I would have to be in the position of calling their bluff and I would have to decide what I would do.

Naz further elaborated

We don't often need new million dollar pieces of equipment … but we never have enough resources to do everything that everybody wants so it’s always a compromise. And you’ve got to be clever trying to get as much money as you can from government … or from donations or from wherever you can get it because there is never enough … When you don’t have enough money … it's “do we need this more than that?” …and “this person's gone without something for ages. and this, it has been condemned for 2 years and it’s no longer repairable” … but you have to just make a decision. You say, “Yes you need this and you need that and so okay, you’ll get this, this time … but I will remind you of it next time we have a decision day”.

Strategies of individuals adopting this subject position included suggesting ideas to influential people, being viewed as indispensable, keeping focused on issues they believed they could influence, being opportunistic, and contesting meaning. Whilst nurses often described experiences where they felt they had been successful, the very context of the circumstances indicated that they were moving from a very poor position of influence. This subject position was primarily informed by dominant positivist discourses of managerialism. Subjugated discourses, however, were evident, often mixed with dominant discourses and included viewing power as with rather than over, valuing personal experience and intuition rather than scientific reductionist tools and developing relationships of trust rather than that of domination.

**Summary and conclusion**

Whilst some of the experiences of nurses in this study have been previously documented, they have been predominantly documented in studies conducted in acute care contexts rather than critical care. These experiences have included oppression and subordination both as nurses and as women, feelings of inadequacy, lack of support from peers, superiors and subordinates, feelings of loneliness, physical violence, bullying and abuse (Attridge, 1996; Chinn, 2000; Davidhizar, 1992; Duffy, 1995; Farrell & Bobrowski, 2003; Glass, 1998, 2003a, 2003b; Hedin, 1987; Hegney et al., 2003; Lee & Saeed, 2001; Nelson, 2001b; Pederson, 1993; Persson & Thylefors, 1999; Randle, 2003; Roberts, 1983, 2000). In addition, administrator bashing, consuming workloads that excluded time for personal life
activities, feelings of loss from resigning, and the suppression of emotions have been reported in studies of nurses (Dunham-Taylor & Klaufehn, 1996; Dwore et al., 2000; Fosbinder et al., 1999; Irurita, 1994; Landstrom, et al., 1989; Robinson-Walker, 1999; Silvetti, 1990). The inability of nurses to speak out about these and other personal experiences has also been documented (Glass, 1998). Further experiences of nurses identified in this study that were not elicited in the literature included nurses feeling watched and snitched upon by peers, the personal rejection and clinical exclusion of nurse managers, the need for nurse managers to become tougher and thicker skinned, and the dilemma of conforming and following lessons in process. Being favoured and rewarded with management functions, not feeling normal, believing self to have a personality defect, and game playing were also experiences of nurses in this study.

Whilst the individual experiences of nurses varied, for many nurses their experience of nursing management was both distressing and alienating. Poor interpersonal relations in the form of hostility, anger, rejection, resentment, and lack of valuing between nurses and nurse managers was overtly evident. The relations between nurses at both similar and different levels of the nursing hierarchy indicated that horizontal violence comprised only part of this issue. This is commensurate with the multiple levels of violence between nurses in academic institutions recently reported by Glass (2003a, 2003b) and Glass and Davis (2004).

Peer relations between nurses were frequently poor and a lack of personal trust often exhibited. Nurse managers were isolated, clinically excluded, and often personally rejected by clinical nurses due to the managerial position they represented within the hospital. Clinical nurses related horrific experiences of being undervalued, unsupported, and victimised by senior nurses and nurse managers. Many nurses acknowledged both horizontal violence and an us and them culture that existed in the relations, and expressed their apparent inability to change this culture. This issue has previously been inadequately described in the literature, however Fedoruk and Pincombe (2000) identified a management-service gap similar to that of Traynor (1999) who identified within a community setting a dualistic divide between the clinical nurse and the nurse executive. It is indirectly evident in other studies (Attridge, 1996; Cara, 1999; Davies, 1995; Kivimäki, 1996; Perry, 1997; Skillings, 1992; Smith et al., 1996).

The data from this study also supports the notion of nurses as individuals possessing complex, competing, and multiple subjectivities with nurses experiencing and reporting multiple perceptions and experiences regarding nursing management. Within the nine subject positions, nurses freely moved and often simultaneously adopted multiple subject positions. Even within these arbitrary categories, individual nurses expressed contradictions, indicating competing needs and interests.
The subject position that predominated in the study was that of the junior novice, which almost all participants adopted at times. This subordinate position was reinforced and reinscribed by organisational and unit practices of peer appraisals, meetings, routine surveillance for defects in ward routine by self and senior staff and a postgraduate critical care course. Disciplinary actions, including lessons in process and reapplying for existing positions enforced this position, whilst subtle concepts such as equating new with novice and aligning nurses with poor intelligence reinscribed this position.

Other subject positions included the detached unemotive individual, the pleaser, being exceptional and elite, the expert clinician, the emotional human, the personal improver/coach, the keeper of order and appearance, and the strategist. All of the subject positions were informed to some extent by dominant instrumental, modernist, and patriarchal discourses. These discourses valued specific economic and scientific knowledges, supported behaviours perceived desirable in men such as strength or toughness, and denied the expression of emotions. They therefore reinscribed the institutional subordination of women. Modernist discourses placed responsibility for experiences directly upon the individual and upheld that being was insufficient and progress was both inevitable and desirable. When intricately linked with managerialism, these discourses, in conjunction with numerous disciplinary technologies, worked to effectively silence and constrain nurses. By participating in these discourses and practices, nurses participated in their own reinscription into positions of subordination. For example, the subject position of the emotional human influenced by these discourses displayed nurses describing their emotions apologetically, explaining these as unusual and describing their attempts to hide these emotions. Emotions were attributed to their problem personality or female gender. Almost all participants prefaced their description or embedded within their description an explanation of themselves as being individually unusual or different for displaying these emotions.

Dominant discourses also informed unit and organisational practices and technologies that supported and reinscribed these subject positions. Disciplinary technologies included everyday activities such as complex webs of meetings that discussed, reported on and encouraged specific behaviours, performance appraisals, peer review processes, and the awarding of promotions and rewards that were management focused. The promulgation and dissemination of ideas to challenge nurses’ thinking and to turn them around reinforced dominant discourses and constructed what was perceived as reality. Dominant discourses upheld that leadership and management were paramount activities and positions far superior to that of the activities and being of a nurse. Being a nurse was not adequate nor enough. Nurses were coached and developed to be managers.
The subjectivity and identity of nurses constructed by dominant discourses homogenised the identity of nurses, as previously reported by Liaschenko (1997), and defined such things as what was special and what was considered progress. *Normal* behaviours of nurses were aligned with what was deemed proper and, concordant with Foucault (1977), were policed more effectively by the disciplinary power of self-surveillance than authoritarian power. Nurses predominantly defined themselves in respect to the identity of their work, including working at a large prestigious hospital, in a *high tech* intensive care unit, having endured a rigorous course, and often in holding a management position. Being this special tempered many of the problems of the work. With the desire for both recognition and status, nurses aligned their identity to their work, the unit, management, and the organisation. Nurses who resigned during the study indicated a deep sense of both downsizing themselves and loss.

Whilst dominant discourses pervaded most subject positions, alternative and subjugated discourses were often elicited. These included notions of teamwork rather than hierarchical relations, equality and improved interpersonal relations, and that of viewing management as superfluous and a little contemptuously rather than as a superior occupation to nursing. Previous studies have identified nurses to be constructed or trained in behaviour and character to be submissive, unquestioning, obedient, and docile with internalised self-discipline (Cheek & Gibson, 1996; Nelson, 2001b; Reverby, 1987). Liaschenko (1997) also identified the homogenisation of identity and instrumentality in relations to other nurses.

Additional marginal and subjugated discourses included those of mateship, collegiality, and friendship. The associated practices, however, were often hidden, relegated to sites away from work, and were limited to unusual or special occasions. Patriarchal behaviours that displayed a distinct separation of personal life from work life were contested and behaviours and activities often denigrated and stereotyped to be those of women were valued. A further alternate discourse included valuing nurses and nursing as being at least equal to the work of management, and questioning the lure and desire for promotion into a management position. Valuing sharing and being human that often constituted ordinary nursing work, and valuing work for the enjoyment of the work itself, was a subjugated discourse within the subject position of being exceptional and elite.

Finally, viewing power as *with* rather than *over*, valuing personal experience and intuition rather than scientific reductionist tools, and developing relationships of trust rather than that of domination, were alternate discourses. Acts of tension and resistance were evident and included contesting spatial order and expertise as well as lack of participation, raising questions, and the thought of political action. Many of the alternate discourses and views expressed were informed by the previous personal embodied experience of nurses and encompassed such things as the influence of mothers and previous work roles. Nurses who
embarked upon alternative discourses, in respect to both what they articulated and what they did, often adopted acts of self-preservation that mediated their position. Other nurses who rejected the dominant discourses ultimately resigned, experiencing a profound sense of loss and self-esteem.

The data supports that little has changed in the social construction of nurses within the clinical environment, except perhaps the technologies and practices that enforce and reinscribe the subject positions of nurses. Previous literature has identified that subordination to the practice of medicine and socialised suppression, as well as the perpetuated myths regarding nursing, eventually undermines nurses’ self-image and confidence (Kalisch & Kalisch, 1987; Malko, 1991). This data would suggest the relations between nurses and nurse managers further undermined nurses’ self-esteem and confidence, and that dominant discourses and associated practices positively constructed and reinscribed nurses to desire and value the concept of management over nursing. Whilst resistance and subjugated discourses were evident, nurses informed by dominant modernistic, instrumental, patriarchal discourses actively participated in constructing and reinscribing their own multiple subjectivities. These dominant discourses were supported by organisational and unit practices that both disciplined and linked with complex webs of technologies constructing meaning and what was perceived as reality. Shifting positions, ambivalence, and contradictions were evident, however, nurses’ subjectivities were predominantly aligned with the identity of the organisation and in achieving the goals of management and the organisation. This positioned nurses in pre-scripted relations with others and constrained their ability to engage in alternate and more meaningful relations.
Chapter Nine

Discussion and final thoughts—*Finale*
Introducing final thoughts—Finale

This chapter, being the final chapter of this thesis, has five specific objectives. Firstly, it revisits the aims of the study, reviewing the extent to which they have been addressed and the significance and implications of the study findings. Secondly, recommendations are made as a result of the study, inclusive of areas for further research. The tensions that are embedded and emanated from the study are then highlighted and examined. This examination is followed by a discussion of validity related to the study and, finally, I conclude with my reflections on the research.

Reflecting on the aims—Strings are playing, hear them saying

The aims of this research I now believe to be ambitious in scope, and perhaps the degree to which they have been fulfilled could only be empirically measured if the possible answers were both finite and known before the study began. This notwithstanding, the theoretical understanding of knowledge brought to this thesis was that knowledge was both contextual and constructed, so that the possibility of multiple views and truths was viewed as likely and advantageous. The enormity of the study reflects the difficulty in attempting to explore, comprehend, and analyse complex interpersonal relationships informed by discourses of the larger social context where relations interconnect with web-like connections, whilst simultaneously not losing sight of the individual voices and everyday experiences of research participants who took part in this social context. The relationship between these two aspects was essential to include in order to soundly address these complex research aims with depth.

The overall aim of this critical ethnography was to explore nurses’ experiences of managing nurses and being managed by nurses by focusing on the local knowledges and clinical practices that constituted the discourses of nursing management within the specific cultural context of a critical care unit. Whilst ethnography was viewed as the reproduction or rewriting of culture, this research rather than just describing the culture, specifically interrogated the culture of nursing management particularly, given that culture was held to be fragmentary and in constant transition.

The first specific aim was to valorise and make space from which nurses from all levels of the hierarchy could speak of their management perceptions and experiences. The data was explicit that the experiences of nursing management for many nurses was both distressing and alienating. The relations between nurses at both similar and different levels of the nursing hierarchy were predominantly distant and often hostile. Even if viewed from a patriarchal perspective that expected working relations to be aloof, the relations in this study
significantly depicted a distinct lack of individual valuing and frequently extended to individual anger, vindictiveness, resentment, rejection, and loneliness. Many nurses acknowledged both horizontal violence and a *us and them* culture that existed between clinicians and nurse managers, and expressed their apparent inability to change this culture.

Whilst alternate relations of friendship and collegiality were observed, this was usually marginalised and constrained to activities outside of work hours, in the tea room, or on night duty. The human response of mutuality, or connectedness, important in significant relationships between women (Glass & Walter, 1998; Jerzac, 2001) was almost absent.

Further aims of this study were to *investigate and interrogate the cultural practices and knowledges that comprised and reinscribed the discourses of nursing management and to identify the marginal, contradictory or subjugated discourses in the form of alternate or oppositional knowledges and practices embedded in nurses’ experience*. The final aim was to *reveal how participants were inscribed by or resisted the various discourses including the multiple and mobile subject positions they adopted*.

The shifting subject positions of nurses displayed that whilst in some subject positions they valued other nurses and the work of nurses, other subject positions frequently involved valuing management over the work of nurses and promoting dominant managerialist discourses that constructed meaning, maintained the status quo, and led to the further subordination of nurses. As nurses did not adopt just one subject position but moved between positions, they frequently rejected both fellow nurses and nurse managers. Often not only were participants marginalised in being neither accepted by nurses or management, they themselves rejected both nurses and nurse managers. The study confirms Roberts’ (2000) description of nursing as a truly marginalised group. However, not all participants experienced this marginality equally. Nurses who held nurse management positions experienced the most rejection from clinicians. One nurse manager explained her delight at not being perceived as a matron. Nurses who predominantly adopted subject positions that questioned or rejected managerialist discourses experienced extreme alienation and, at times, individual persecution from managers. Those who were perceived to be aligned with both management and clinical nursing were rejected by both managers and clinicians. Apart from describing themselves as *the meat in the sandwich*, these nurses experienced loneliness. They frequently articulated and enacted conflicts and dilemmas regarding their actions and beliefs.

Similar to the recent finding of Glass and Davis (2004), violence was not just horizontal, but also vertical. Vertical violence travelled up the hierarchy from clinician to nurse managers, however, its greatest impact was often down the hierarchy where it was supported by both positional power of authority and dominant discourses. Whilst nurse managers experienced
feeling abnormal and lonely, nurses lowest in the hierarchy often thought they had personality defects, were physically and verbally abused, and some reluctantly resigned.

Dominant instrumental and patriarchal discourses informed many of the subject positions adopted by nurses. These discourses valued specific economic and scientific knowledges, supported behaviours perceived desirable in men such as strength and toughness, and denied the expression of emotions. Together they reinscribed the institutional subordination of women. Modernist discourses placed responsibility for experiences directly upon the individual and upheld that being was insufficient and progress was both inevitable and desirable. When intricately linked with managerialism these discourses, in conjunction with numerous disciplinary technologies, worked to effectively silence and constrain nurses to maintain positions of subordination and to actively reinscribe themselves into these positions. Disciplinary technologies included everyday activities such as complex webs of meetings that discussed, reported on, and encouraged specific behaviours, performance appraisals, peer review processes, the awarding of promotions, and rewards that were management focused. The promulgation and dissemination of ideas to challenge nurses thinking and to turn them around reinforced dominant discourses and constructed what was perceived as reality. Dominant discourses upheld that leadership and management were paramount activities and positions far superior to that of the activities and being of a nurse. Being was not adequate, nor certainly being a nurse. Nurses were coached and developed to be managers.

The subjectivity and identity of nurses was also constructed by dominant discourses that homogenised the identity of nurses, as previously reported by Liaschenko (1997), and defined such things as what was special and what was considered progress. Normal behaviours of nurses were aligned with what was deemed proper, and concordant with Foucault (1977) were policed more effectively by the disciplinary power of self-surveillance than authoritarian power. Nurses predominantly defined themselves in respect to the identity of their work and measured their own self-worth against the criteria and values of dominant discourses. This included working at a large prestigious hospital, in a high-tech intensive care unit, having endured a rigorous course, and often in holding a management position. Being this special mitigated against many of the undesirable aspects of the work. With the desire for both recognition and status, nurses aligned their identity to their work, the unit, management, and the organisation. Nurses who failed to completely align themselves or who contested the dominant discourses found themselves the object of technologies that problematised their being. The lure of the perceived status and special identity was evident in the response of nurses who reluctantly resigned during the study and indicated a deep sense of both downsizing themselves and loss.
Whilst many nurses believed that they chose to play games which were distinct from real reality where the games started and stopped, was difficult to define. There was little understanding of what effect this game playing had in reconstituting or constructing reality. Nurses who embarked upon alternative discourses, in respect to both what they articulated and what they did, often adopted acts of self-preservation, such as caring for the unpopular patients. This mediated their position. Other nurses who rejected the dominant discourses ultimately resigned in frustration of not feeling heard and not feeling valued, despite their love of the work that they were performing. They identified that there was no prospect of work relations and work arrangements improving to a level which would maintain their desire to continue employment.

Alternative and subjugated discourses included notions of teamwork rather than hierarchical relations, equality, and improved interpersonal relations, and that of viewing management as superfluous and a little disdainfully, rather than as a superior occupation to nursing. Previous studies have identified nurses to be constructed or trained in behaviour and character to be submissive, unquestioning, obedient, and docile with internalised self-discipline (Cheek & Gibson, 1996; Nelson, 2001b; Reverby, 1987). Mateship, collegiality, and friendship were also a subjugated discourse with the associated practices often hidden, relegated to sites away from work, and limited to unusual or special occasions. Patriarchal behaviours that displayed a distinct separation of personal life from work life were contested, and behaviours and activities often denigrated and stereotyped to be those of women were valued. Other alternate discourses included valuing nurses and nursing as being at least equal to the work of management and questioning the lure and desire for promotion into a management position. Valuing sharing and being human that often constituted ordinary nursing work and valuing work for the enjoyment of the work itself, was also a subjugated discourse. Viewing power as with rather than over, valuing personal experience and intuition, and developing relationships of trust rather than that of domination, was a further alternate discourse. Acts of tension and resistance were evident and included contesting spatial order and expertise, as well as lack of participation, raising questions, and the thought of political action. Many of the alternate views expressed were based upon the previous personal embodied experience of nurses and encompassed such things as the influence of mothers and previous work roles.

**Significance—Don’t get me wrong**

This study is significant in enabling the numerous experiences of nurses to be voiced and valorised when prior literature in this area has predominantly concentrated on measuring aspects of roles, functions, and satisfaction of nurses or previously only valorised the stories of individual nurses in senior management positions. It is also significant given the
predominance of dominant instrumental and patriarchal discourses that permeate and inform most nursing management texts.

The significance of these research findings are firstly of concern to women. Lather (1991) stated the goal of feminist research is to correct the invisibility and distortion of female experience in ways to end women’s unequal social position and to improve social existence by revealing socially constructed distortions and empowering or enabling a positive change. Furthermore “moving from silence into speech is for the oppressed, the colonised, the exploited, and those who stand and struggle side by side, a gesture of defiance that heals, that makes new life and new growth possible” (hooks, 1990, p. 340). As well as de-silencing and re-claiming voice of the various experiences of women (Glass, 1998; hooks, 1990; Roberts, 2000), this study has also identified some of the ways in which dominant discourses reinscribe women into subordinate positions and the practices and technologies that support this. Of further significance, this study has highlighted the many ways in which nurses complicitly and unintentionally reinscribe themselves into positions of subordination. Alternate and subjugated discourses have also been distinguished.

For nursing as a profession, the study has significance in respect to its aims for professional recognition and its current modes of organising. It appears that the inherent and entrenched current hierarchical mode and culture of organising that values management above the discipline of nursing further works to reinscribe the poor value attributed to nursing. Furthermore, these relations that structurally place the most senior nursing officer alone and vulnerable at the top of the hierarchy are the antithesis of the relations seen in occupations deemed as professions where the hierarchical pyramid is inverted and expert clinicians jointly hold the most prestigious positions.

Lastly, the results of this study are significant when it has been reported that there is a shortage of nursing leaders and the international shortage of nurses is viewed as a crisis (AHWAC, 2002; AIHW, 2003a; Buchan & Edwards, 2000; Buerhaus et al., 2000; DEST, 2001; DEWR, 2004; DHAC, 2000; Finlayson et al., 2002; Kimball & O’Neil, 2002; SCAC, 2002; US Department of Health and Human Services, 2002). Previous recommendations to address this crisis have overwhelmingly recommended further management training for nurses (Department of Health, 2001; DEST, 2001; Royal College of Nursing Critical Care Nursing Forum Steering Committee, 2003; SCAC, 2002). The results from this study question the appropriateness of these recommendations.

Rather than an authorial authoritative prescription for action, I wish to leave this research open-ended in how readers may interpret specific actions that could be taken. Prescription legitimates foundational notions of truth that this very thesis has been attempting to subvert.
However, despite my attempt at being open-ended, I believe the thesis underpinned by critical methodologies is relatively explicit in many aspects, particularly in respect to the experiences of nurses. I anticipate readers may select and reflect upon the research, taking from it that which they find useful, and discarding that which is not. Therefore, rather than make specific prescriptions for actions which risk reinscribing notions of truth and limiting further possibilities, I provide an overview of what I would rather term implications and recommendations.

I also note that relations of power often sit in tension, such that any shift in the balance is likely to engage complex counter mechanisms attempting to realign the existing balance. Also the depth and complexity of change required is embedded in discourses well established and enmeshed within large organisations and society, such that lone actions not connected in supportive webs are likely to be perceived of as being pathological or abnormal. Adapting the concept from Fine and Weis (1998), I would advocate that we do not need to fix nurses, but to fix the context in which they live. However, shifting to a more positive position that advocates reality as constructed, then despite the enormity of the task reality can be reconstructed. By acknowledging and exploring shifting subject positions, the construction of individual subjectivity and identity can be seen to be multiple, fragmented, and unfixed, such that alternate subjectivities are infinite possibilities perhaps limited only by thought and imagination. The creation of that space is important. Implications and recommendations from this study, inclusive of further research, are now briefly outlined and, consistent with the methodology, are positioned from critical, feminist, and postmodern perspectives.

Implications and recommendations for further research—Imagine …

The major implications from this study for nursing as a profession relate to nurses explicitly and foremost valuing their own practice and fostering a culture that genuinely permits individual diversity to alter the existing pre-scripted relations that constrain nurses’ ability to engage in more meaningful interpersonal relations. Questioning current discourses and practices that value specific economic and scientific knowledges, support patriarchal behaviours, and silence nurses is essential. The articulation of alternative discourses that value women and nursing is crucial for reconstructing a reality that does not result in women and nurses feeling abnormal, rejected, and alienated.

Firstly, I strongly recommend that the interpersonal relationships between nurses and nurse managers be centered rather than marginalised to the realms of unimportance. That these relationships are integral to women and nurses is of equal importance to their functionality as workers. Even as workers, nurses’ and nurse managers’ functionality is compromised. This
concept needs to be further articulated, discussed, explored, documented, and examined in respect to it being intolerable for both women and nurses. The notion of horizontal violence needs to be replaced with intraprofessional violence that indicates violence that moves up, down, and sideways. This has also been identified by Glass and Davis (2004) in nurse academics. Depicting nursing violence as horizontal attaches blame to clinical nurses and denies the complex power relations that underpin the violence.

Of equal importance is that nurses value their practice, themselves, and what they do as nurses. Strategies to support and foster nurses being are essential, including interactions in individual relationships to the creation of further designated clinical positions of authority such as clinical nurse consultants and advanced clinical practice nurses. These clinical positions should be of equal or higher prestige than nurse management positions. Improving nurses’ self-confidence is also commensurate with being valued. Therefore, actions within organisations need to be carefully scrutinised to see if what is articulated is followed through, how and to whom it is achieved or if it is just rhetorically stated rather than implemented. Articulating value that is not genuine or without intention to action furthers the subordination of nurses. Valuing the emotional engagement of nurses with patients exemplifies this situation and whilst it is espoused it requires open acknowledgement and active support. The contradictions of espousing to value the importance of giving emotional care whilst concurrently insisting and priviliging a high level of functionality and expectation that nurses apologise for, turn off and block out their emotions, requires further serious investigation.

A further recommendation is that nurses think closely and critically about the concept of management and leadership, including how nursing is organised within health care or higher educational organisations. The very concepts of leadership and management should be removed from the pedestal and recognised as power relationships rather than the presumption that all leadership and leaders are good. The argument put forth in respect to the organisation of nurses is not that nurses should emulate other professions but that, whilst overtly claiming professional status, nursing has not reorganised its fundamental internal or intraoccupational social relations and values either socially or structurally to constitute what may be deemed a profession. Professional relations in themselves are not antithetical to large bureaucratic organisations. Valuing the work of the occupation above that of the work of management and the subsequent structural and social intraoccupational relations is important. Whilst management work is viewed as a superior occupation to that of the work of nurses, nurses will be managed and nurse managers and leaders will be marginalised. Lifting the concept of leadership or management from its lofty pedestal to a space of scrutiny would be a brave start. The implications for nurses as an occupational group need to be
articulated if nurses wish in any way to shift their continual subordination. Exposure and comparison with other work environments may assist. Senior nurse managers who work predominantly in a patriarchal and hegemonic environment require support to sustain their position. Alternate structures that provide for multiple individuals to have significant shared power reduces the vulnerability of a single individual and mirrors the organisation of other so called professions. However, reconceptualising organisational relationships, rather than mirroring the dominant professions, is a preferable alternative and was recommended by Ferguson (1984) in her feminist critique of bureaucracies. She advocated for the transformation of bureaucracies and, consonant with Wheeler and Chinn (1989), for women to develop their own ways of organising and leading.

Awareness by nurses that they police each other and of the surveillance mechanisms by which this is supported and encouraged should be gained. The celebration, not constraint of difference, is important. This was aptly articulated by Leslie during the study.

Something that I would like to foster is an acceptance of different people … we all get ‘pissed off’ on occasions the way people do things but at the end of the day—if as long as the patient’s best interests are at heart there are different ways of achieving the same outcome. Different people have different ways of approaching it and we need to be a bit tolerant of each other. There needs to be a whole different culture … of tolerance of acceptance of difference … managers need … to be confident enough in their position and smart enough to realise that people who ask questions aren’t threatening but rather that from questioning you can improve things.

It is a further recommendation that nurses as women continue to question, explore, and push the boundaries to excess in respect to their identity and subjectivity so as to be able to shift and to develop alternate subject positions. A further alignment with feminist thought that questions and subverts dominant hegemonic discourses and practices would be advantageous and could be facilitated through further research. Simultaneously, the processes and methodologies utilised in this study and other postmodern feminist studies could be further explored, refined, and elucidated. Alternates, discourses, and practices could be further identified via research and the articulation and documentation of nurses’ voices be valorised within these discourses to engage in the construction and reconstruction of meaning. This should be inclusive of emotional issues for nurses, as the emotional silencing and suffering of nurses is highly evident. Research that interrogated and examined aspects of nurses’ work they find fulfilling and rewarding, what they believe to be special, and what they constitute as a reward, would be beneficial. Questioning, scrutinising, wondering, and most of all imagining, perhaps are the most important activities nurses can engage in to create and discover alternate possibilities and practices.
Two more specific recommendations from this study are offered. Firstly, that nurses responsible for educational programs, both undergraduate and postgraduate, intently examine the hidden socialisation processes within the programs and actively aim to foster further confidence in nurses. Secondly, those nurses assuming management positions question their ability to continue clinical practice as a nurse and the mechanisms available to support their continued practice. Attitudes and resources provided towards supporting the clinical practice of nurse managers may reflect how clinical practice is valued.

Finally I applaud and note the words of Henry and LeClair (1987), particularly in viewing subjectivity to be constructed by discourses, which manage meaning. For nurses to gain further abilities and confidence in articulation is important, so as to be able to themselves engage in contesting and constructing meaning.

Words captivate and compel, or hobble and bag … Words rich in meaning generate excitement, and the use of metaphors can give added meaning to work …. Nurses need to give added attention to the use and subtleties of language, to the need to develop strong linguistic skills, to remain sensitive to the values implicit in varying lexicons, and to appreciate the discretions often ‘implied’ in verbal and written forms of communication.

(Henry & LeClair, 1987, p. 19)

The Tensions—It’s a puzzlement

This study has highlighted several issues of tension, which have been intentionally left both unanswered and in tension. Whilst causing me some unease, I have attempted to keep open these tensions rather than to succumb to providing definitive and concrete answers. The paradox is explicitly apparent in attempting to not provide definitive closure in a thesis where traditional modernist research would expect a comprehensive and explicit summary of results that claimed absolute truth for progressing the knowledge on the topic. Multiple positioning has enabled the critical position of author to speak with relative conviction regarding the experiences of women and nurses and has attempted to valorise their experiences and make space from which they could speak. However, when adopting a more postmodern position the tension is apparent as the clear explication of knowledge discovered as truth risks legitimising foundational notions of truth. I therefore note and draw attention that this knowledge on the topic is both contextual and my knowledge. Furthermore, as author, my own construction intertextually limits and constructs this text. Perhaps I should have signed the declaration of originality at the beginning of this study rather than now at the end. By locating myself into the research, the intent was simultaneously to acknowledge the twin construction of author and data. In this respect I agree with Ribbens (1989), who asserted we should attempt to face up to some of the paradoxes as honestly and as explicitly as we can, rather than trying to deny the power we do have as researchers. Rosenau (1992)
also commented on the benefits of postmodern research as attempting to leave endings and indeed the total text as open to a more active reading. By not providing closure on these issues, I aim to leave open the conditions for further possibilities.

The issue of individual agency versus constructionism resonates throughout this thesis and reflects my own confrontation with this conflict. I do not have a definitive answer to this issue and continue my quest now with some reserved ambivalence. The tension is highly evident in the analysis of the data that frequently displays the temptation to provide causality for conflicts and at other times stops short. The notion of power is primarily depicted in a Foucauldian sense, however, alternate feminist views are also included. The dilemma is also evident in the very nature of this study. Without belief in some agency there would be little value in conducting the study at all, however, the notion of social construction is heavily depicted. Hopefully the theoretical framework and methods appropriated in the study have highlighted the complexity of issues relating to power, subjectivity, and agency. My concluding thoughts revolve around the importance of these issues and the often invisible yet strong seduction to complicity and unintentionally participate in our own reinscription and subordination. I would tentatively argue that rather than listen and search for the music of our own soul, we have been seduced to take ownership and to write and sing songs that have not delivered their promise.

The issue of representation has led previous feminist authors working within postmodern paradigms to attempt alternate methods for presenting and representing their work. Authorial responsibility for attempting to represent truth, or even truths versus responsibility for acknowledging intertextuality and the partial and incomplete nature of representation, is also evident in this thesis. Combining giving voice with interruption to subvert the interpretation has been utilised by Czarniawska-Joerges (1994), Lather (2000), and Davis (1998). Positioning the author as a mobile subject and the use of musical metaphors was similarly utilised in this thesis as attempts or “struggles for social justice while working against the humanist romance of knowledge as cure within a philosophy of consciousness” (Lather, 2000, p. 305-307). Perhaps smaller, but also of significance in issues of representation, are those of participant confidentiality and the word count limitations of the written text within a modernistic practice of writing a research thesis. Much data was regrettably excluded and therefore not represented in order to ensure the former issues were met.

As a researcher with intent to improve the lives of women and nurses, I believe the methodologies provided some ability to engage in a critical process of research without the arrogance of believing that either I knew best or that I could discover easy answers to improve their lives. I commenced the ethnography with a strong belief in the complexity of the field and some hesitancy regarding my ability to contribute. In faith with this, I found the
nurses within the study were deeply thoughtful and insightful of their issues, as well as generous in sharing aspects of their lives. As an academic, researcher, and woman I feel my responsibility is to contribute by attempting to ensure that, theoretically and methodologically, the research practices embedded in the processes and the written texts of the research are as thoughtful, insightful, and generous as the nurses and women who participated. Issues of validity are now discussed prior to my final reflections.

Validity—*From U2 to INXS*

Concerns are raised with postmodernist research that preoccupation with discourse alone can obscure the lived realities of subordinate groups with neglect of the social context and de-emphasis of economic and material relations of power (Humphries, 1998). Concerns have also been emanated at critical studies for further oppression through the potential negation of multiple oppressions and essentialist theorising (Davis & Glass, 1999; hooks, 1984). This study, that combines critical, feminist, and postmodern methodologies, is most appropriately evaluated for its validity according to criteria that are consistent with the methodology (Lather, 1993; Webb, 1993). Acknowledging the postpositive notion and epistemological position that knowledge itself is virtual and that there is no right answer, Ayres and Poirier (1996) advocated that research processes must be constructed with an eye to vigorous self-awareness. That the research is *worthwhile* was also considered important by Harding (1991) and Webb (1993) who advocated that feminist research should engage in issues of concern to women. Bent (1993) further expanded the expectations of feminist research that it should utilise

methods that attempt to reduce power inequalities within research relationships, report women’s experiences in their own terms whilst also attempting a structural analysis of the conditions of their lives, and to include within that analysis the role and influence of the researcher themselves. (p. 422)

Lather (1993) outlined four specific frames of what she terms transgressive validity specific to feminist poststructural research where validity is multiple, partial, and endlessly deferred rather than a legitimisation of knowledge as truth. Within this validity is viewed as a space of constructed visibility of the practices of methodology and entails a “reflexivity that attends to the politics of what is and what is not done at a practical level” (Lather, 1993, p. 676). I interpret her frames to represent suggested aspects of validity that can be applied to postpositivistic research that explore different problems of inquiry and within themselves aim not to reinscribe normative foundationalism. These four frames I have used as the criteria to assess validity within this research, bearing also in mind the former comments regarding research validity.
**Ironic validity**, the first frame, foregrounds the insufficiencies of language, produces truth as a problem, and includes the generation of research practices that take the crisis of representation into account (Lather, 1993). Within this study notions of music were metaphorically appropriated as a strategy to intentionally interrupt and subvert the written text and to draw attention to the limitations of text with the reminder of the aesthetics of music. Writing the thesis from the authorial position of a shifting, nonunitary or mobile subjectivity (Bloom, 1998; Ferguson, 1993), also subverted the notion of depicting a real reality or a description of truth, whilst simultaneously acknowledging myself and topic as twin construction (Richardson, 2000). Multiple perspectives help to elucidate alternative interpretations which might escape consideration in providing a unified version of reality (Savage, 2000). I therefore constructed the ethnography not as an objective description, but attempted to locate myself and to roam freely in the research, to trouble constraining boundaries, to reflect the complexities, and to recognise and draw attention to the interpretive and partial views depicted in text.

**Paralogical validity** is the second frame of validity described by Lather (1993). Within this frame, research fosters differences and heterogeneity. It searches for the oppositional in daily practices and lets contradictions remain in tension. Differences were fostered within this study by highlighting both the multiple subject positions of participants and of the author. Contradictions within and between subject positions were given accent rather than summarily explained. Marginal and subjugated discourses, together with oppositional practices, were identified. Rather than identify and reinscribe binary categories of gender, participants were represented with androgynous names. This was not performed without thoughtful concern for potentially hiding issues of women. For this reason participants were identified within the binary gender categories of male and female within chapter seven. The propensity for critical theories to reinscribe universalised subjectivity has been noted by Luke (1992).

**Rhizomatic validity** is the third frame suggested by Lather (1993). Within this frame Deleuze and Guattari’s (1987) concept of functioning rhizomatically in an unorderly, non-linear, tangled, complex, and network-like fashion is used. Rhizomatic validity unsettles from within and generates new locally determined norms of understanding working against the reinscription of systematicity and authority and placing conventional discursive procedures under erasure. By seeking the views of nurses and their experiences within their local context, locally determined multiple norms of understanding could be elicited. The identification of multiple complex subjectivities and contradictory and alternate discourses subverted and contested the unitary, androcentric, dominant notions of nurses’ identity and
subjectivity and valorised the multiple and marginal discourses embedded in nurses’ experience.

*Voluptuous validity* is the final frame advocated by Lather (1993). This frame examines the effect of the inclusion of a female imaginary on the research where the maternal/feminine exceeds categories and disrupts with excess the limits of the hegemonic male imaginary. Drawing on the work of Irigary (1985), Lather (1993) contended the intent is to create a space where women in their multiplicity can become. Rather than distanced objectivity, authority comes from engagement and self-reflectivity, explicit incompleteness, tentativeness, and the creation of space for others to enter. Ethics and epistemology are brought together. The use of shifting subject positions of both participants, and particularly that of author, disrupted with excess the notion of a unitary androcentric self. Authority was constructed from *being* in the field with participants as a nurse and woman, from asking participants to check and validate their interview transcripts, and from processes of documented reflection, including the documentation of reflective field notes. Rather than prescribe actions as a result of the research study results, recommendations were made to leave open the possibility for further imagining of possibilities.

Ethics was intrinsically tied to epistemology where the critical and feminist intentions of the research included valuing women and their individual opinions. This included ensuring their confidentiality was privileged over the desire to maximise detail within the ethnography. Participants were aware they could withdraw at any time, could exclude the researcher from aspects of the clinical field, and could withdraw any information from their transcripts. The interviews were conducted with sensitivity toward each participant and at times and places of mutual convenience. Participants were informed that if the interview upset them in any way by reflecting on traumatic events, they could be assisted to access additional support. One nurse manager requested to withdraw approximately three pages from her interview transcript, which was honoured. Many nurses returned their transcripts thanking me for the opportunity and interest in hearing them talk about issues that were of great personal concern to them. Many described frustration at previously not being heard and that the process in itself felt like a debrief or emotional outlet. Participants were given a clear understanding that one of the intentions of the research was to give them voice or to make space for them to speak. Given that nurses’ communication methods privilege verbal means (Street, 1992), the intention is to complete this process by presenting the research at conferences, as well as documenting it in publications. Failure to do so would risk that the research process in itself became an instrument for maintaining the status quo.
Reflections on the journey—Final notes

Metaphorically speaking, the result of the experience of this research has for me been like turning on the radio expecting to hear a familiar song and instead finding that several stations are playing at once. No longer is there one tune, but I can listen intently to hear the feminist melodies whilst soft they are still audible. I can tune out to the patriarchal and instrumental sounds and hear different melodies—some soft, some strong. The old music had the comfort of predictability and believing the predictability was perhaps also a positive that is not commensurate with the multi-melodies now audible. However, in adjusting to the complexity and understanding that the new melodies are constructed and emitted similarly to the old songs, then the freedom to hear and to turn and to tune into what is individually and aesthetically pleasing is immense. Some sounds are painful. Some sounds are overbearing, and others are monotonous. The painful ones are hard to bear and it would be tempting to tune out, except that I can’t. Perhaps I have been constructed with a social conscience to abhor violence and to believe in equality. Perhaps because I am a woman, a nurse, a mother, a wife, a daughter, a student; I am not sure.

No longer do I berate myself for the multiple positions I hold, but instead applaud the possibilities they afford me. I recognise that the construction of my subjectivities reflects not a fault in my own ability to attain the perfect self, but that of the dominant discourses that shape the larger world. Not being good and being different is not always bad. Being conscious of discourses and their ability to construct meaning and reality whilst unsettling also opens possibilities for alternate constructions. Given this research and the webs of power identified, the complexity of such a task should not be underestimated. Therefore, I conclude that this process of research has reconstructed me and how I now perceive my own identities. It was with shock in analysing the data that I found I could see myself in every subject position I identified. The space the study afforded me, however, I have found wonderful, and I question if the daily work requirements of other women like myself heavily involved in the continual doing of work for others consistently occupies, as well as colonises, their mind space. Feminist literature and concepts I found the most challenging to understand, however, I believe as a woman that it was mostly from these that I personally gained.

Finally, I would like to reach for a piece of music to summate my feelings, which would probably be Ave Maria. Having stronger spiritual beliefs rather than specific religious convictions, this music I find expresses more ably than I can in words my profound longing. Being bereft of the auditory, I return to the written text and draw on the words of Sorrell (1994) who stated that “as we search for knowledge embedded in nursing practice, we can
reach beyond our governing gaze to formulate research texts that convey new understandings of human experiences”. I would further add that by continually examining and questioning assumptions (even dearly held assumptions) that hide our very reinscription and construction, we may work toward uncovering our unwitting but complicit reinscription. Furthermore, by creating space to think, critique, subvert, exceed, contest, and imagine, and by articulating, sharing, and constructing these different meanings, alternate possibilities to positions of suffering subjugation and violence may be pursued by women and nurses.
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Appendix One

Southern Cross University Ethics Approval
Appendix Two

Southern Cross University Information Sheet
Appendix Three

Southern Cross University Consent Form
Appendix Four

Broad Framework of Open-ended Interview Questions
Can you tell me about your role and function within the hospital?

What is the most pleasing/satisfying aspect of your role?

What have been your experiences of being managed by nurses?

Can you think of an experience that is memorable?

How did it make you feel?

How do nursing management decisions affect you as a person?

What do you think influences the decisions of nurse managers?

Can you do all the things you would like to do?

Do you yourself manage nurses?

How do nurses relate to you and your decisions?

Is gender an issue for you at work?

What affect do nurse management relations have on you?

In what ways could nurse-management relations be different?

What are you passionate about in respect to nursing management?

**Note:** These questions were utilised as a broad framework to stimulate conversation. The questions provided the starting point for discussion and therefore were rarely addressed in specific order. They did not limit or preclude other points of discussion.