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'Unsaid' voices of middle-level women nurses’ experience of Western Australian public hospitals: an integrated feminist postmodern ethnography

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Southern Cross University

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‘Unsaid’ Voices of Middle-Level Women Nurses’ Experience of Western Australian Public Hospitals: An Integrated Feminist Postmodern Ethnography.

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

Department of Nursing and Health Care Practices
December 2007
Declaration of Originality

I certify that the substance of this work has not previously been submitted for any other degree and is not being submitted for any other degree. I certify that, 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: ..............................................................................................................

Name: Helen Kathleen PANNOWITZ

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

This thesis is dedicated to the eight women nurse participants whose narratives and experiences inspired and humbled me.

A special dedication is made in loving memory to mum (Kit), dad (Snow), and step-mother (Lucy) – each inspiring in different, unique and valuing ways.

Of special note, my love and thanks extend to Mary Maude Winter, a wonderful and ‘gorgeous’ friend and mentor who continues to infuse in me her passion for nursing education but more so to enjoy the wonders of life.
Acknowledgements

My deepest heartfelt thanks extend to Associate Professor Nel Glass and Dr Kierrynn Davis, for their unconditional friendship and open sharing of their expertise. From the inception for this research Nel and Kierrynn facilitated a frame of confidence and enthusiasm within which I knew something special would emerge.

Professor Beverley Taylor and Chris Game, as senior nursing staff within the Department [nee School] of Nursing and Health Care Practices, Southern Cross University. They fostered a learning culture in which ‘risky’ research could be pursued. I was privileged to learn from the bi-annual qualitative research seminars where they created, supported and nurtured many colleagues towards the achievement of their higher degrees.

An enduring love to my family for their confidence and encouragement to be the best I can be: my sister, Margaret; my nieces, Melissa and Fiona; my nephew, Michael; Liesl, my step-daughter; Martin, my father-in-law; Susan, Charles, Carl and Daniel, my in-law family; and all of their respective partners; and my dear friends of many years.

For the pride in my effort, commitment to my learning and his patience — no words effectively describe my thanks and depth of love for my husband, Piet. I am continuously empowered and transformed within our relationship.

Special thanks is extended to my colleagues and friends, Susan Golding, for her expert transcription of the ethnographic data and Susan Thompson for her suggestions regarding writing tense and punctuation.

And, a very special thanks is extended to Craig Huxtable for his outstanding focus to exceptional drafting detail in creating my Ethnographic Research Method Model.
Abstract

The context for this research was the socio-political, culturally constructed, lived experience of eight women nurses who held middle-level positions in two Western Australian public hospitals. Glass and Davis’ (1998) integrated feminist postmodern model for nursing research framed the design for the ethnographic investigation.

The researcher used an innovative self-developed trifocality method: realist; critical feminist; and feminist postmodern to critique ethnographic data against the research aim and objectives and reflexively engaged with the women nurses to reveal unacknowledged individual and collective insights.

Participant observation, critical conversation, and reflective field/journalling were used as triangulated data collection methods. The methodology revealed the local, particular, historical, taken-for-granted and traditionally gender-biased subjugated voices of individual women nurses as legitimate sites for the production of knowledge and insights.

The trifocal data analysis revealed multiple intersecting layers of meanings and insights. The participants unacknowledged ‘unsaid’ experiences were viewed as exemplar ‘states of being’, or subjectivity positions, of their multiple and temporal realities. Inherent within the subjectivity positions was their personal, professional and corporate efforts, assumed as self-managing strategies and implicit knowledge, to enact work roles.

Deeper critique, applying feminist poststructuralism (Lather 1991b) and postmodern notions of power/knowledge networks of relationships (Foucault 1980b) revealed three competing socio-political culturally constructed discourses. Firstly, the participants’ were embedded within an empowering ‘Discourse of Values Attributed to Nursing/Between a Rock and a Hard Place’. Secondly, they were influenced by, and resistant to the patriarchally dominant ‘Discourse of Bureaucratic Managerialism Discourse/Absence of Care’. Thirdly, they functioned within the influence of the disempowering ‘Discourse Medical Science/Working the Margins’.
This research contributes to the knowledge base of scholarly work that exists about nurses, women nurses specifically, concerning the meaning of the experiences of practicing in the confluence of corporate and professional responsibilities. At the personal participant level the insights contribute to emancipatory consciousness-raising. The insights also positively contribute to the recommendations made in The Report of the Western Australian Study of Nursing and Midwifery (Pinch & Della 2001). The insights may evoke wider awareness of the disempowering influence of managerialism upon professional practice and inter-professional relationships. Finally, the unique trifocal data analysis method contributes to the body of nursing and social science research knowledge.
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<tr>
<td>ACHS</td>
<td>Australian Council on Health Standards.</td>
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<td>AHMAC</td>
<td>The Australian Health Minister’s Advisory Council.</td>
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<tr>
<td>ANMC</td>
<td>Australian Nursing and Midwifery Council.</td>
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<tr>
<td>CEFF</td>
<td>Clinical Education for the Future Project 2003.</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer.</td>
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<tr>
<td>CNS</td>
<td>Clinical Nurse Specialist.</td>
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<tr>
<td>DoHWA</td>
<td>Department of Health Western Australia.</td>
</tr>
<tr>
<td>DON</td>
<td>Director of Nursing. In Australia, this was a leadership nursing position. The nurse was a member of the health organisation’s executive team. Depending on the size of the health care organisation this role may have had line management to: one or more nurses who were also members of the hospital’s executive team; middle-level nurses; or no line management responsibilities. The title may also have included Nurse Executive.</td>
</tr>
<tr>
<td>EQuIP</td>
<td>Evaluation and Quality Improvement Program.</td>
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<tr>
<td>HREC</td>
<td>Human Research Ethics Committee of Southern Cross University.</td>
</tr>
<tr>
<td>MLWN</td>
<td>Middle-Level Woman Nurse/s (ethnographic participants). Experienced registered nurses (NBWA, Division 1) who were merit selected into senior nursing positions within a WA public hospital into the role of Clinical Nurse Manager, Nurse Manager, or Clinical Nurse Specialist.</td>
</tr>
<tr>
<td>NBWA</td>
<td>Nurses Board of Western Australia.</td>
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<tr>
<td>N³ET</td>
<td>National Nursing and Nursing Education Taskforce Report 2002.</td>
</tr>
<tr>
<td>NHMRC</td>
<td>National Health and Medical Research Council.</td>
</tr>
<tr>
<td>NHS</td>
<td>United Kingdom National Health System.</td>
</tr>
<tr>
<td>NREC</td>
<td>Nursing Research and Ethics Committee.</td>
</tr>
<tr>
<td>NSW</td>
<td>New South Wales.</td>
</tr>
<tr>
<td>Nurse</td>
<td>A nurse who was registered in Division 1 under the Nurses Act 1992: “Division 1 shall contain the names and other particulars of those persons whose qualifications and experience have been approved in writing by the Board as rendering them capable of practising independently as professional nurses” (WA Nurses Act 1992. Section 34. 25).</td>
</tr>
<tr>
<td>Nurse Executive</td>
<td>A nurse who held a merit-selected executive, tenured or contract position, within a public hospital. The position may have line-managed middle-level nurses and resource management of one or several units or the whole hospital. An alternate title may have been Director of Nursing.</td>
</tr>
<tr>
<td>OCNO</td>
<td>Office of the Chief Nursing Officer, DoHWA.</td>
</tr>
<tr>
<td>SONP DMF</td>
<td>Scope of Nursing Practice Decision-Making Framework 2005, Nurses Board of Western Australia.</td>
</tr>
<tr>
<td>WA</td>
<td>Western Australia.</td>
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<tr>
<td>WADET</td>
<td>Western Australia Department of Education and Training.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition/Description</td>
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<td>Affirmative Postmodernism</td>
<td>‘While agreeing with the critique of modernity, affirmative postmodernists have a more hopeful, optimistic view of the postmodern age in that they do not abandon the author completely, but they reduce the author’s authority, offer options for public debate and allow researchers as the authors of projects to offer tentative insights for readers’ interpretations and discussion’ (Roberts &amp; Taylor 2002a:530).</td>
</tr>
<tr>
<td>Consciousness Raising</td>
<td>‘Sharing of stories in a safe environment for women brings to the forefront the realization of the oppressive features that restrict women’s lives. This process, therefore, results in self-awareness, self-growth and subsequent motivation for social change’ (Glass 2000:357).</td>
</tr>
<tr>
<td>Corporate Management</td>
<td>‘It is inextricably connected with the development of bureaucracy and indeed derives its importance from the need for strategic planning, coordination and control of large complex decision-making processes. . . It also led to the belief that industrial and other work organizations could be more efficient if responsibility for policy and planning and overall control was separated from implementation, routine operations and production tasks. Cadres of specialist managers and systems of surveillance and control were thus established to monitor work flow and quality, and to discipline the workforce, while other functions were also created (finance, marketing, corporate management)’ (Flynn 1999:23).</td>
</tr>
<tr>
<td>Deconstruction</td>
<td>‘A process of breaking down and validating each woman’s individual experience of oppression, rather than accepting all experiences of oppression as the same for all women’ (Glass 2000:374).</td>
</tr>
<tr>
<td>De-silencing</td>
<td>A feminist theoretical term coined by Glass (1998:125) in which women progress actively from a state of ‘silence’ (‘the historical silencing of women’s voices and experiences by patriarchal discourses and the re-presentation of “women” as other (Luke 1992 in Glass 1998) through to de-silencing to reclaiming their voice and gaining awareness of changes within themselves – evidence of the surfacing of empowerment’ (Glass 1998:125).</td>
</tr>
<tr>
<td>Discourse</td>
<td>‘A discourse consists of a set of common assumptions that, although rarely consciously recognized, provides the basis for conscious knowledge . . . Discourses are not about objects, they constitute them and in the practice of doing so conceal their own intention’ (Cheek &amp; Porter 1997:119). ‘Contemporary discussions concerning an issue/subject/topic, often in an academic way’ (Glass 2000:374).</td>
</tr>
<tr>
<td>Empowerment</td>
<td>Self-power that provides personal confidence to know how to overcome oppression. ‘Through sharing women’s stories their individual voices are heard and their reality is acknowledged and validated’ (Glass 2000:356).</td>
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| Enlightenment                    | Insight about the cause of the oppression that is blocking the
<table>
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<th>Term</th>
<th>Definition/Description</th>
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<tr>
<td>Emancipation</td>
<td>individual/group’s freedom.</td>
</tr>
<tr>
<td>Epistemology</td>
<td>‘A framework or theory for specifying the constitution and generation of knowledge about the social world’ (Glass 2000:374).</td>
</tr>
<tr>
<td>Experience</td>
<td>The MLWNs’ narratives represented ‘a primary embodiment of [their] understanding of the world, of experience, and ultimately [them]selves: the typical way in which experience is framed and schematized and orderly worlds constructed’ (Rapport 2000:75).</td>
</tr>
<tr>
<td>False Consciousness</td>
<td>Not knowing what you do not know; believing something is true when it really is not.</td>
</tr>
<tr>
<td>Feminism</td>
<td>‘A philosophy with a prime focus on women and their oppression within patriarchy’ (Glass 2000:374).</td>
</tr>
<tr>
<td>Feminist Ontology</td>
<td>‘Putting feminist theory into practice – that is applying feminist principles directly from feminist premises – the action of doing feminist research’ (Glass 2000:368).</td>
</tr>
<tr>
<td>Feminist Research</td>
<td>‘Always has women’s experiences of marginalization or oppression as a focal point’ (Berman, Ford-Gilboe &amp; Campbell 1999) of awareness and exploration, and ‘feminist research involves a collaborative focus, for the researcher and participants, on emancipation’ (Glass 2000:368).</td>
</tr>
<tr>
<td>Governmentality</td>
<td>Appropriating Cheek’s (2000:27) description of Foucault’s (1979) explanation of governmentality as ‘characterised by pervasive matrices of power which entail the surveillance and disciplining of both individuals and entire populations: the population is both subject and object of government’; inclusive of Gordon’s (1991:2 emphasis in original) interpretation of Foucault’s term of ‘government’ as ‘meaning “the conduct of conduct”’: that is to say, a form of activity aiming to shape, guide or affect the conduct of some person or persons’ and which included the concept of ‘the government of one’s self and of others’.</td>
</tr>
<tr>
<td>Hegemony</td>
<td>‘Leadership/superordination of one state or group of people over another or others. This superordination is often perceived as ‘natural’ by the subordinate state or group of people, rather than as socially constructed’ (Glass 2000:374).</td>
</tr>
<tr>
<td>Intersubjectivity</td>
<td>‘A way that a feminist researcher involves herself in a research study, demonstrating that she “lives” her feminist beliefs. The most common way or method is through reflective journalling’ (Glass 2000:374).</td>
</tr>
<tr>
<td>Lived Experience</td>
<td>‘The knowledge humans have of how it is to live a life in regard to being someone or something unique in everyday situations’ (Roberts &amp; Taylor 2002a:534).</td>
</tr>
<tr>
<td>Managerialism</td>
<td>Managerialism’s focus was toward four values: ‘economic efficiency; faith in the tools and techniques of management science; top-down class consciousness which serves as a unifying force among managers for the benefit of organisational wellbeing (hierarchy and control); and managers as utilitarian moral agents’ (Edwards 1998:frame 4).</td>
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<td>Marginalisation</td>
<td>‘Often an experience of an oppressed person created by an oppressor’s actions; for example, the oppressed person feels that she is not listened to, heard or valued for her opinion, beliefs, feelings as much as someone in a more powerful position’ (Glass 2000:374).</td>
</tr>
<tr>
<td>Objectification</td>
<td>‘In feminist terms the way women are seen only in relation to their bodily parts and not known for their total selves’ (Glass 2000:374).</td>
</tr>
<tr>
<td>Ontology</td>
<td>‘One’s being or the way one acts in one’s world; for example, the way a person “walks their talk” ’ (Glass 2000:374 emphasis in original).</td>
</tr>
<tr>
<td>Oppression</td>
<td>Domination by one or more persons, politics, rules, policies, or other factor that prevented the individual/group from experiencing freedom. Of nurses and women’s oppression: ‘Nursing has been constructed by powerful discourses including those of medicine and gender, in which our society’s dominant ideologies are enshrined’ (Delaclour 1991:413).</td>
</tr>
<tr>
<td>Patriarchy</td>
<td>‘A system of male authority which oppresses women through its social, political and economic institutions’ (Glass 2000:374).</td>
</tr>
<tr>
<td>Postmodernism</td>
<td>‘A critique primarily of the construction of language’ (Glass 2000:374). Francis (2000:23 footnote 3 emphasis in original) described poststructuralism in that ‘one cannot objectify the language which one is immersed in, and that language can be interpreted in many different ways, so dominant storylines or claims to truth can be “deconstructed” and dismantled’.</td>
</tr>
<tr>
<td>Feminism</td>
<td>‘A philosophy that supports and values the social contextual experience and difference of unique individuals and rejects the generalization of those experiences’ (Glass &amp; Davis 1998:44 In Glass 2000:364).</td>
</tr>
<tr>
<td>Poststructuralism</td>
<td>‘Power must be analysed as something which circulates, or rather as something which only functions in the form of a chain. It is never localised here or there, never in anybody's hands, never appropriated as a commodity or piece of wealth. Power is employed and exercised through a net-like organisation. And not only do individuals circulate between its threads; they are always in the position of simultaneously undergoing and exercising this power. In other words, individuals are the vehicles of power, not its points of application’ (Foucault 1980:98). Townley (1993:frame 2) interpreted Foucault’s postmodern explanation of power as, ‘power is not something that is acquired, seized or shared, something one holds onto or allows to slip away. Rather, power is relational; it becomes apparent when it is exercised. The exercise of power perpetually creates knowledge and, conversely, knowledge constantly induces effects of power. It is not possible for power to be exercised without knowledge, it is impossible for knowledge not to engender power’.</td>
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<td>Professional</td>
<td>The disciplines of nursing and midwifery. A summary version of the typical way the Western culture viewed professional: ‘There is a body of expert knowledge over which the profession exercises a degree of control and, in the purest form, a monopoly of practice. The profession sets standards of training and controls entry to the group. Once professional membership has been achieved, members of the profession relate to each other on a collegial basis. Within a profession, individuals – as holders of specialist expertise – expect to exercise a degree of autonomy over their work and their work processes’ (Ferlie, Ashburner, Fitzgerald, &amp; Pettigrew 1996:168).</td>
</tr>
<tr>
<td>Reflexivity</td>
<td>‘A process of “bending back” on one’s self, of turning back one’s experiences on oneself (Steir 1991 in Glass 2000); therefore, the way one reflects on a situation and subsequently acts on the reflections to improve one’s situation’ (Glass 2000:374).</td>
</tr>
<tr>
<td>Self-Managing Strategy</td>
<td>Appropriated from a Foucauldian (1988, 1994) perspective of the technologies of the self and self-surveillance - the self judging the self and developing strategies to survive and thrive in the work culture and care for oneself. Also, the enactment of values that reflect a person’s vision to achieve goals.</td>
</tr>
<tr>
<td>Subjectivity</td>
<td>‘Personal experiences and personal truths that may or may not have some resonance with other people’s subjective experiences and truths’ (Roberts &amp; Taylor 2002a:538).</td>
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<tr>
<td>Transformation</td>
<td>The physical, psychological and/or spiritual ability to change oneself to cease being oppressed, or be able to remove the factors that cause the oppression.</td>
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<tr>
<td>Trifocality</td>
<td>‘An analytic model that views the data in 3 steps. As an example, feminist postmodern ethnographic strategy in which women’s stories are revealed through 3 lens – realist, oppositional (deconstructive), and reconstructive, thereby producing the trifocality’ (Glass &amp; Davis 2004:91).</td>
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<tr>
<td>Unsaid</td>
<td>A feminist term appropriated by Glass (2003b:189) that she related to research women participants who, ‘in the safe trusting reflexive relationship with a feminist ethnographer, were able to speak out for the first time of destructive experiences where they had not been heard, did not talk, sensed being invisible, were excluded and isolated themselves. The safe environment was also one in which the woman’s identity was protected’.</td>
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Appendix

Appendix 1. Research Proposal Approval by Human Research Ethics Committee of Southern Cross University; Information Sheet and Consent Form.
Chapter 1.
Framing the Ethnography
Every woman has something important to say about the disjunctures in her own life and the means necessary for change
(Lather 1991c:xviii).

Introduction
The reader is welcomed to this thesis which centre’s the voices of eight inspiring women nurses who were practicing in middle-level positions in two Western Australian (WA) public hospitals during the years 2003 to 2006. These women nurses’ stories and revealed insights may evoke optimistic possibilities for other nurses to celebrate their empowering practices that seek to transform discourses that imbue an absence of care by inscribing nursing values.

This integrated feminist postmodern ethnographic thesis comprises seven chapters. The thesis is constructed to conform to academic research convention. However, as it is a postmodern thesis, it deliberately includes some postmodern twists which aim to engage the reader in the potential for critical reflection of alternate readings. Unlike an open-ended, unstructured anthropology this ethnography was specifically framed within the cultural context of women nurse’s day-to-day and local experiences.

Structure of this Chapter as a Prelude to the Thesis
There are five sections to this chapter. Throughout the thesis where it was appropriate to facilitate ease of reading, sections and sub-sections have been used. In the process of ‘sectioning’ the material the intention was to create an organised flow for presenting the multiplicity and interconnecting constructs of the ethnography. In this chapter a chapter introduction, several sections and a chapter summary are included. In subsequent chapters an introduction and summary for the majority of sections within a chapter are also included.

Section one of this chapter includes an outline for the stimulus of my research interest. This leads to stating the research focus, question, objectives, methodology, aim, and participant inclusion criteria. The style of writing used in this thesis is then also clarified.
Section two of this chapter introduces the gap in nursing knowledge within which I was confident that my research was located. Also included in this section is a brief introduction to the broader Australian and WA sociopolitical cultural context which partially framed the external cultural influences of the nurses during the ethnography.

A brief introduction of the scope of philosophical perspectives that informed the ethnography is provided in section three.

A brief introduction to the ethnographic triangulated data collection methods is presented in section four. This section also introduces the innovative trifocal multi-phased data analytic methods applied to the ethnographic data and includes a figure of the ethnographic research method.

The final section in this chapter provides an overview of the ethnographic insights. This section also introduces the contribution the ethnography can make to the body of nursing and critical social science knowledge.

Below, in section one the specific focus of the ethnography is presented.

**Section 1. Introducing the Ethnography**

**The Stimulus for the Ethnography**
At the time of undertaking the research my practice in the world of nursing had spanned more than thirty five years, in various Australian States (twenty five years in WA) and also Singapore and Malaysia. My enthusiasm and passion for the values of nursing, nurses and the significant benefits nurses have brought to the health arena inspired my work and research interest for this study.

In particular, this ethnography emerged from my interest in continuing education for nurses. From the early 1980s I commenced working as a hospital-based Inservice Nurse Educator in a team who provided outstanding professional development education for practising nurses in WA. The team was led by a woman nurse. She was visionary, openly mentored her staff, and challenged and won the battle for nurses to be provided with funded continuing education.
Her approach was emancipatory in intent and action. The Director of Nursing (DON) for the hospital at the time brought to her role passion and optimism for the value for nurses, especially toward her nursing staff in senior and middle-level positions. This DON and our team’s Director inspired our team’s pursuit to foster confidence and capability for nurses to have a voice in the health care practice arena at all professional levels. The group of nurses that interested and intrigued me the most was registered nurses in middle-level positions. Their roles, which encompassed endeavouring to practice within the confluence of corporate and nursing professional agendas, seemed contradictory, perplexing, and complex. Yet this group was the linch-pin to achieving the core goal for a hospital – the best health care possible for patients. However, even within an encouraging learning culture, anecdotal comments from many middle-level nurses drew my attention to their concerns that their influence in local and broader political arenas was limited. They were not heard.

The position titles for this level of nurse included the following: charge nurse, nurse manager, clinical nurse manager, and clinical nurse specialist. These nurses were notable for their extensive nursing experience. They continued to interest me as I moved into academia. At that time, I was teaching management and leadership principles to a variety of nursing students, practicing registered nurses, and nurses in management positions throughout South East Asia. An impetus for this investigation was my experience and unabated assumption that the voices of many practicing middle-level nurses continued to be poorly acknowledged. Their role as expert practitioners, leaders, managers, problem-identifiers and solvers, negotiators and conflict preventor/resolver was rarely heard or validated as integral to the functioning of hospitals.

In 1999 the possibility to undertake doctoral research with women nurses in middle-level positions in the WA public health system became an exciting prospect. I serendipitously met with Associate Professor Nel Glass during her postdoctoral research visit to WA universities. Nel had been a friend and colleague from our days as postbasic students during our neuroscience nursing course in 1976 in Sydney, New South Wales (NSW). While catching up on our histories, Nel inspired me to have the courage to fulfil my interest to publicly acknowledge women nurses, by centering their voices in a doctoral thesis. My
interest was the professional validation of their lived experiences, knowledge and self-created ways of practicing in the nexus of their professional values and corporate responsibilities. Dr Kierrynn Davis, our neuroscience course lecturer (in 1976), mentor and great friend, with Nel, became my supervisors. These colleagues had extensive nursing research experience, deep commitment for excellence within the nursing profession and, of nurses, and unconditional valuing for sharing and nurturing a mutual learning environment. I knew my research journey would be personally transformative and liberatory.

With Nel and Kierrynn’s friendship and expertise I have been humbled by my learning journey. More particularly, I am proud to foreground the voices of the women nurse participants. The thesis formed part of the body of nursing knowledge in which the nurse participants became ‘de-silenced’ (Glass 1998:125) and who could proudly and with integrity lay claim to being legitimate knowledge producers.

My research focus, question, objectives, aim, and methodology are presented below as are the criteria I applied for participants to enter into the research.

**Research Focus**
The research focus for this ethnography was:

An integrated feminist postmodern ethnography with public hospital middle-level women nurses in Western Australia.

**Research Question**
What meanings do middle level women nurses (MLWN) attribute to their experience of practising in Western Australian public hospitals?

**Research Objectives**
The ethnography specifically sought to explore realist experiences, self-managing strategies, power relations and discourses. The specific objectives are outlined below.
Research Focus | Research Objective
--- | ---
1. Experiences | To explore and reveal issues (experiences) that are common, different, unique and exceptional that foster (empower) and constrain (disempower/oppress) the participants’ personal, professional and corporate efforts toward their own empowerment, emancipation and transformation.
2. Self-Managing Strategies | To explore and reveal ways that the participants create opportunities within their work setting for enhanced self-management.
3. Power Relations | To describe and critique the participants’ perceptions of the impact (power relations) on them of the hospital’s organisational culture in regards to their personal, professional and corporate responsibilities.
4. Discourses | To review and critique the discourses (common assumptions) that frame the practice of Middle Level Women Nurses

Research Methodology

The research was informed by an integrated feminist postmodern ethnographic methodology.

Research Aim

It was not known how or to what extent middle-level women nurses practising in WA public hospitals empowered themselves to achieve their combined professional and corporate responsibilities from their perspective. My research aimed to enhance and expand upon the existing knowledge about nurses whose roles incorporated a multiplicity of responsibilities.

My research interest thus focused my intention to reveal and critique with individual women nurses their knowledge and perceptions of ‘the power relations at work and the manner in which knowledge is socially constructed and ideologically embedded’ (Street 1992:10). The power relations that particularly interested me included the potential/actual tensions between participants’ corporate and professional responsibilities from their perspective as MLWNs. My interest was to challenge the status quo (Lather 1991c).

The discourses that framed these nurses’ taken-for-granted understandings of their practice realm were considered worthy of exploration (Cheek 2000). From
this perspective I anticipated opportunities could surface for the MLWNs to have their voices and reality acknowledged and validated (Glass 2000), for them to reflect on practice (enlightenment), uncover oppression (emancipation) if this existed, and reveal the transforming ways that enhanced their professional and corporate responsibilities (empowerment) (Cheek 2000; Fay 1987; Glass 2000; Walter 2003; Webb 1993).

It was the potential revealing of the MLWNs’ unacknowledged knowledge that I considered important as relevant contributions to the body of nursing knowledge. Such knowledge and insights, viewed from an integrated feminist postmodern ethnographic perspective, had not previously been explored or documented.

**The Participants: Inclusion Criteria**
The inclusion criteria for invitation to participate in the study were:
- Participants were registered in Division 1 with the Nurses Board of Western Australia (NBWA).
- Women nurses with a minimum of three years experience in an appointed middle-level senior nursing position in a WA public hospital.

**Writing Style Throughout the Thesis**
It is relevant, from the start, to acknowledge that I chose to write this thesis using the traditional academic style rather than an ‘evocative’, ‘fragmentary’ or ‘messy’ style, the latter having a closer affinity to a postmodern text (Lather 1989:9). Foley (2002:479) indicated that few ethnographies have been written in ‘full-blown postmodern’ text. Further, Foley’s (2002:481) reflection of his own ethnographies as ‘realist storytelling style’ which endeavoured to be ‘personal and reflexive, thus more open, accessible, and public’ aligned with my feminist ethics for the style of writing I chose for this thesis.

I breach traditional academic protocol as an objective author. Instead, throughout the thesis I have included my reflexive comments that emerged from my intuition, emotion and introspection about my experience with each MLWN. As with the style of critical writers, my approach was transparently political. I believed that the voices of women nurses who practised in middle-level public
hospitals had relevance to contemporary political issues confronting the global shortage of nurses and the poor retention rates experienced world-wide. Further, I believed that the nursing profession continued to have a low level of influential power within the larger political health arena of government.

Throughout the thesis, where I believed paraphrasing would distort a scholar or researcher’s original meaning I drew upon direct quotation. My writing also aligned with how Lather endeavoured to inscribe a postmodernist approach within a traditional academic style to her work in that:

The accumulation of quotes, excerpts, and repetitions is also an effort to be ‘multi-voiced,’ to weave varied speaking voices together as opposed to putting forth a singular ‘authoritative’ voice. (1989:9 emphasis in original)

I also acknowledged that ‘words are always poor representations of the temporal and evocative life world’ (Altheide & Johnson 1998:297). I endeavoured to foreground the individual MLWN’s voices as my principal means ‘to understand, validate and acknowledge a woman’s experience from her words and stories’ (Glass 2000:352 emphasis in original). From my feminist perspective my interest was to challenge ‘the pervasive androcentricism evidenced by research that, at best, speaks for women and at worst silences them’ (Cosgrove & McHugh 2000:frame 6). I further endeavoured to enunciate the women’s tacit knowledge; that which was not overtly articulated by them but that which I observed, felt, considered and analytically revealed that they took for granted.

In foregrounding the MLWNs’ voices, within non-unitary and mobile subjectivity ways, I used the convention of sentence-like structure, i.e. the insertion of punctuation, as well as unchanged conversation. My aim was to stay close to their realities, voices and experiences inherent in their narratives, and within my observations and reflections.

This ethnographic thesis aligned with Denzin and Lincoln’s (2000a) discussion of the crisis of representation in qualitative research as occurred in the mid-
1980s. At this time, research and writing became more reflexive and ‘called into question the issues of gender, class, and race’ and which sought different ‘models of truth, method, and representation’ (Rosalso 1989, in Denzin & Lincoln 2000a:16). Denzin and Lincoln referred to several authors’ work in their text *Handbook of Qualitative Research*, and their view that:

Writing as a method of inquiry moves through successive stages of self-reflection. As a series of written representations, the field-worker’s texts flow from the field experience, through intermediate works, to later work, and finally to the research text, which is the public presentation of the ethnographic and narrative experience. Thus fieldwork and writing blur into one another. (2000a:17)

The American Psychological Association (APA) Publication Manual, 5th ed., 2001 was the style used throughout this thesis, inclusive of the author-date referencing system and according to the rules of the language of origin (APA 2001:219). Only references cited in the thesis are included in the Reference List. A glossary of acronyms and specific terms used throughout the thesis is presented in the opening pages of the thesis.

To protect the identity of the hospitals within which I undertook the ethnography I chose not to include copies of my research proposals that were approved (July 2002, February 2003, and March 2003) by the respective Nursing Research and Ethics Committees. However, included in Appendix 1 is the approval for my research proposal by the Human Research and Ethics Committee of Southern Cross University.

In writing the thesis, I also chose to structure the presentation applying the past tense as a contextual frame in which the writing-up of the research was undertaken post-data analysis. In referring to published literature I also wrote in the past tense. The exception to my style was the use of the present tense when introducing the content of each chapter, section and sub-section. Parallel to the research process, however, I undertook to prepare the majority of the chapters, especially those of literature and research review, methodology and methods. I also developed chapter two throughout the ethnographic data
collection and analysis periods as this formed an important part of my reflective journal and understandings of the sociopolitical and professional background context within which the MLWNs practised at the time of the ethnography.

Inclusive throughout the thesis are two principal threads. Firstly, I frequently referred to one or more of the research objectives as integral to the critique or discussion in the thesis. Secondly, where it was relevant to the discussion, I also incorporated my assumptions. My assumptions have not altered on completion of the research.

Thus, next in section two I present a brief introduction to the gap in nursing knowledge within which my research interest was located.

**Section 2. Locating the Gap in Nursing Knowledge**

The gap in nursing knowledge within which this ethnographic thesis was situated is briefly introduced in this section. In chapter two, ‘The Sociopolitical Context of MLWNs’, I present relevant detail of the broader sociopolitical context within Australia and WA that was viewed as potentially influential upon the research participants during the ethnography. In-depth research and literature critique is presented in chapter three ‘Discourses Impacting Upon MLWNs’.

No research within Australia or internationally was identified which had focused on women (or men) nurses who specifically practised in public hospital’s organisational middle-level hierarchy informed by an integrated feminist postmodern ethnographic perspective. My research interest was to contribute to the international nursing professional dialogue from an integrated feminist postmodern methodological perspective of this specific group of nurses. No research was identified that explored the commonalities and differences in meanings this level of women nurses ascribed to their day-to-day experiences.

Extensive international review and critique of qualitative and quantitative research demonstrated numerous projects and scholarly works related to middle-level nurses in respect to practice issues. Literature was searched that took into account a wide range of discourses surrounding or involving nurses in
management and clinical specialty positions. Several Australian research projects were identified that applied critical feminist, postmodern and integrated feminist postmodern methodology and methods that included nurse participants who practised in senior and executive hospital positions. However, no research was located that adequately addressed my research question and objectives.

Scant nursing research was identified, one being Australian, that described in detail an analytic process applied to an integrated feminist postmodern ethnography in which multiple levels of insights were revealed (Glass & Davis 2004).

The sociopolitical cultural background impacting upon Australian nursing professional practice also indicated a space within which to locate my research. In chapter two I develop in more detail those issues that I considered related to the broader sociopolitical cultural context within which the research participants were practicing. The changing sociopolitical terrain for the Australian nursing profession throughout the ethnography continued to be relevant and an impetus to progress the research. For example, several Australian national and State reports, one national Industrial Relations Commission ruling and a decision by NBWA, were important literature that supported a gap in nursing knowledge within which to locate my research interest. These reports, below in Table 1. ‘Federal and WA State Reports and Decisions Pertinent to the Ethnographic Context’, were noted to frame the professional nursing agenda and which inspired me to pursue my research interest and to locate it within WA. The WA nursing professional responses to some of the these reports were, at the time, taken up by the combined efforts of the Office of the Chief Nursing Officer (OCNO), Department of Health WA (DoHWA), and the NBWA. I was privileged to be invited to many forums convened and to contribute to the dialogue related to these reports during the period of data collection.
Emergent from my initial literature and research critique and ongoing critique I was confident of a gap in nursing knowledge within which to locate my research interest.

In section three, below, I provide an introduction to the breadth of the various philosophical perspectives that informed the ethnography.

**Section 3. Scope and Philosophical Frame of the Ethnography**

In-depth detail of the philosophical and theoretical perspectives that informed the thesis, as methodology and method, is presented in chapter four, ‘Integrated Feminist Postmodern Methodology and Method’. As an overview and introduction, some of the key theoretical perspectives are presented in this section to demonstrate the importance that the research methodology and method aligned with my research interest and which had strong epistemological and ontological links (Glass & Davis 1998, 2004; Walter, Glass & Davis 2001).

**Aligning Methodology with the Research Focus**

In affirming the methodology was most appropriate to the research focus, question, aim and objectives, I initially had to navigate my way through the ‘paradigm wars’ (Oakley, 2000:23). This entailed developing an understanding of scientific positivist research and that of qualitative social science research methodologies and methods. Ramprogus (2005:frame 1) asserted the need for ‘all philosophical perspectives and approaches [to] be seen as of equal value and necessary to the understanding of the complex nature of the phenomenon.
that nursing is’. Having critiqued the various research paradigms, positivist and empirical methodologies, phenomenology and grounded theory, as common methodologies applied in nursing research (Roberts & Taylor 2002a), I believed these did not fit with my research question, aim and objectives.

It was within the methodological genre of an integrated feminist postmodern ethnography (Glass & Davis 1998, 2004) that I believed my research interest could best be approached. Inherent in this frame of theoretical reference, the reflexive and intersubjective approach of ‘being with’ (Glass 1998:125) the participants and not undertaking research ‘on’ them (Lather 1991b:24) and the feminist political emancipatory potential in this methodology and method aligned with my values, interests and interpersonal skills. My values also aligned with Rappaport’s (1990:53) assertion that ‘research changes those who participate in it’ and challenged that the ‘means of acquiring data do not contradict the aims of empowerment’.

As a concise description of an integrated feminist postmodern methodology I drew upon the principal perspectives proposed by Glass and Davis’ and that they asserted as relevant to nursing research:

Acknowledging each woman’s individual and unique sociopolitical experience within their own particular context; validating the difference and diversity of perceptions within that context; recognizing the impact of the “oppression narrative within each woman’s “everyday” life”; and “creating opportunities to deconstruct each individual woman’s stories regarding her experience”. (2004:83 emphasis in original)

Chinn and Kramer’s (1995:4) epistemological frame for nursing knowledge underpinned the location of my ethnography, in that ‘different ways of knowing and of creating knowledge are each, in their own right, useful for some purpose’. Further, Chinn and Kramer’s (1995) description of nursing practice was pertinent. These authors framed nursing practice to mean ‘the experiences a practicing nurse encounters during the process of caring for people’ (Chinn & Kramer 1995:160). I expanded their description of nursing practice to include those nurses whose focus was also directly toward the care of nurses who care for patients.
Within the professional and organisational controlling constructs of the public hospitals in which the MLWNs’ practiced, Foucault’s (1980) postmodern theoretical concepts of power/knowledge, self-surveillance and governmentality were especially pertinent for my theoretical consideration as these related to the work practices and experiences for the MLWNs. For example, Foucault's conception of power was an integral consideration in the investigation, in that:

> Power must be analysed as something which circulates, or rather as something which only functions in the form of a chain. It is never localised here or there, never in anybody's hands, never appropriated as a commodity or piece of wealth. Power is employed and exercised through a net-like organisation. And not only do individuals circulate between its threads; they are always in the position of simultaneously undergoing and exercising this power. In other words, individuals are the vehicles of power, not its points of application. (1980:98)

Of additional and more specific influence for me was Foucault’s (1980:142 emphasis in original) assertions in that ‘power is “always already there”, that one is never “outside it”, that there are no “margins” for those who break with the system to gambol in.’

**Inclusion of Researcher Assumptions**

In keeping with feminist postmodern research principles I included throughout the thesis relevant personal assumptions (Chesney 2000). The following forms an initial frame of assumptions that I brought to the research context.

My assumptions of what it meant to be a woman nurse within the cultural context of WA hospital settings derived from my nursing experience in a variety of practice, managerial, education, consultancy and executive settings. I was familiar with the multiplicities of diverse, often competing and contradictory cultures within which nurses functioned (Glouberman & Mintzberg 2001; Lumby 2000; Manias & Street 2001a; Porter-O'Grady 1992). The dominant medically constructed hospital culture, one constructed upon modernist patriarchal scientific assumptions, and ‘which typically encompass the prevailing power relationships’ (Field 1998:79; Falk Rafael 1996), in my experience, had
permeated and was embedded in all aspects of the nurses’ and other health workers’ practice (Bloor & Dawson 1994; Chiarella 2000a, b; Horsfall 1996; Irurita, 1990; Mason, Backer & Georges 1991; Street 1992). Such domination had created an imbalance of power in relation to legitimated knowledge of health care practices in which alternate understandings, such as that by nurses, had been suppressed (Manias & Street 2001b). From a postmodern perspective Spitzer (1998) also emphasised the conflict for nurses to fulfil their ethical code and their commitments to the institution. Further, this kind of domination upon nurses was reflective of oppression of women in general (Attridge 1996; Chin 2000; Duffy 1995; Glass 1998, 2003a, 2003b; Speedy 2000).

Of my research, I was under no illusions of the possibility for liberating outcomes for the participants. Rather, I assumed, from a feminist perspective, the research process may have opened a space for consciousness raising and enlightenment. This assumption was framed within the context of Glass’ ontological and epistemological feminist stance in that:

One cannot transform oppressive experiences and subsequently become empowered without a comprehensive understanding of the theoretical frameworks of oppression. (1998:122)

Further, by framing my research interest within the political and individually focused integrated feminist postmodern ethnography, I fully acknowledged that as the researcher I could not ‘directly capture lived experience’ (Denzin & Lincoln 2000a:17) of the women nurse participants. I acknowledged that this ethnographic thesis was my representation of my engagement in the field with the participants (Denzin & Lincoln 2000b). Of the thesis in which I brought the eight MLWNs and their cultural experiences to the foreground, I also drew attention to my acknowledgement that their experiences were neither common to each other nor common to other women nurses in similar employment situations. However, the methodology supported my interest to advance the MLWNs’ multiple voices as the principal authorial experts of their experiences. It also fostered ‘valid representations of [their] reality (Elliott 2005:22) whilst also
retaining their unique embodiment and connectedness as whole individual women (Glass 2003b).

In the next section the multiplicity of methods that were applied to ethnographic data collection and data analysis are introduced.

**Section 4. Triangulated Qualitative Research Methods**

In chapter four ‘Integrated Feminist Postmodern Methodology and Method’ I detail the suitability for my choice of triangulated methods that I applied to ethnographic data collection. What follows is an introduction to these methods. A model for the method that I developed is presented on page 38, at the end of this section as Figure 1. ‘Research Method’.

The use of triangulation as multiple methods (Denzin & Lincoln 1994, 2000a; Fenech & Kiger 2005; Glass & Davis 2004; Halcomb & Andrew 2005; Lincoln & Guba 1985, 2000; Tuckett 2005) was applied in a number of areas within this ethnography. Triangulation aimed to support deep understanding of the MLWNs’ experiences, provide rigour, support validation (Tuckett 2005) of the emergent insights and engage the participants in the empowering process of validating their ‘voices’ as legitimate meaning makers.

The methods I applied to collect data included participant observation, field notes, critical reflective journalling and critical conversations with each research participant. These methods provided the most appropriate opportunities to be immersed in the cultural context of each research participant. Integral to these methods were a number of feminist research principles, inclusive of: establishment and maintenance of trust and reciprocity, non-hierarchical relationships, critical reflexivity and intersubjectivity. These research practices fostered my depth and breadth of emic and etic appreciation of the MLWNs’ lived experiences with them and not imposed upon them and provided a safe environment for them to speak their ‘unsaid’ (Glass 2003b:189).

In chapter five ‘Revealing MLWNs’ Voices - Trifocal Methods’ my application of trifocality as data analytic methods is detailed. This chapter also includes the
step-by-step process that I developed, as a multi-phased approach, to reveal the multiple frames of insights emergent from the MLWNs’ data.

Glass and Davis’ (2004:91) ‘trifocality’ methodic approach and Fenech and Kiger’s (2005) research alerted me to the value of applying multiple analytic lenses to the same set of data. While integrated feminist postmodern research was finding a place in nursing research, analytic methods were given scant attention in the literature. Glass and Davis (2004:91) posed the idea that examining data at three different levels produced a ‘trifocality’ that allowed the data to remain relevant to participants, uncovered knowledge relevant to the nursing profession and ‘rejected the idea that deconstruction leads to endless unpackaging that had no point of arrival’. Further, Savage (2000b) also highlighted that multiple levels of analysis could reveal alternative interpretations of the data.

In reviewing the literature, no prescriptive analytical approach could be located that would effectively address my research question, aim and interconnected objectives. Nor did the literature reveal a structured approach to critique data from a feminist postmodern approach. What emerged from my deep immersion in the data was a need for an innovative multi-lensed method. I also needed a method which permitted me to critique the data and to reflexively engage with the MLWNs in revealing unacknowledged multilayered individual and collective insights. The trifocal multi-phased data analysis model that I developed applied perspectives of realist, critical feminist and integrated feminist postmodernism to the MLWN’s individual data (refer to Figure 1 Research Method overleaf).

The third area where I applied a triangulation approach was in my use of the feminist intent to foreground the MLWNs’ voices by way of multiple member checks (Lather 1991b). At three points during data analysis, each MLWN was invited to reflect and comment upon different aspects of my preliminary analysis. These multiple member-checks also aimed to foster a consciousness-raising emancipatory intent for the MLWNs as the research process unfolded. By applying multiple member checks my aim was also to foster a feminist research approach of inclusivity. This method also aided in research validity and rigour and provided an audit trail.
Figure 1. Research Method.
In the next section I provide a brief introduction to the emergent analytic insights and the possible contribution the research has to the body of nursing and social science knowledge.

Section 5. Overview of the Ethnographic Outcomes

Emergent Ethnographic Insights
The emergent insights and the impact of the discourses and associated subjectivity positions are explored and critiqued in detail in chapter six ‘The Voices of Middle-Level Women Nurses’. My analytic approach assured the emergent insights could be directly aligned with realist MLWNs’ data and voices. A list of the six frames of emergent insights is presented below in Table 2. ‘Trifocal methods – Multiple Emergent Frames of Insights’.

Table 2. Trifocal methods – Multiple Emergent Frames of Insights

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<th>Frame of Insight</th>
<th>Name of Frame of Insight</th>
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<tr>
<td>1st Frame of Insights</td>
<td>Critical Feminist Analysis of Realist Concepts and Emergence of Multiple Subjectivity Positions</td>
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<td>2nd Frame of Insights</td>
<td>Postmodern Discourses Influencing the MLWN’s Cultural Context</td>
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<tr>
<td>4th Frame of Insights</td>
<td>Feminist Postmodern Critique of MLWN’s Realist Experiences</td>
</tr>
<tr>
<td>5th Frame of Insights</td>
<td>Insights of Feminist Postmodern MLWN’s Self-Managing Strategies</td>
</tr>
<tr>
<td>6th Frame of Insights</td>
<td>Emergent Implicit Knowledge Inherent in MLWN’s Self-Managing Strategies</td>
</tr>
</tbody>
</table>

From an individualised analysis there were common emergent insights for this group of MLWNs. The MLWNs were located to be practicing in three culturally constructed discourses and a number of multiple and mobile subjectivity positions. These emergent insights were found to be experienced in different ways for each MLWN. The revealed discourses and subjectivity positions are tabulated in Table 3. ‘Emergent Discourses and Related Mobile Subjectivity Positions of the MLWNs’.
Table 3. Emergent Discourses and Related Mobile Subjectivity Positions of the MLWNs

<table>
<thead>
<tr>
<th>Discourse</th>
<th>Subjectivity Position</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Values Attributed to Nursing</strong></td>
<td>Nurse Advocate – Passionate Connection</td>
</tr>
<tr>
<td>– Between a Rock and a Hard Place</td>
<td>Patient Advocate – Prime Focus</td>
</tr>
<tr>
<td></td>
<td>Self – Different in the Moment</td>
</tr>
<tr>
<td></td>
<td>Relationship with Nurse Executive – An Invited Voice (2 x MLWNs)</td>
</tr>
<tr>
<td><strong>Medical Science</strong></td>
<td>Medical Dominated Unit – Unchallengeable Sovereignty</td>
</tr>
<tr>
<td>– Working the Margins</td>
<td>Professional Frustration – Fear of Future Loss of Nurses</td>
</tr>
<tr>
<td><strong>Bureaucratic Managerialism</strong></td>
<td>Relationship with Nurse Executive – An Uninvited Voice (6 x MLWNs)</td>
</tr>
<tr>
<td>– Absence of Care</td>
<td>Limited Authority – Marginalised Expert</td>
</tr>
<tr>
<td></td>
<td>Government Employee – The Silenced Majority</td>
</tr>
</tbody>
</table>

The following is a brief outline of the contribution the research process and revealed insights propose to make to the body of nursing and critical social science research and knowledge.

**The Ethnography’s Contribution to the Body of Knowledge**

The various emergent insights from this ethnography are proposed to have an important contribution to the body of nursing knowledge, nursing research methods and critical social science methods in general. The potential implications of the ethnography are suggested to also have value for non-nurse professional women who are employed in middle-level positions in public organisations. In chapter seven ‘Concluding Remarks and Where to from Here’ I explored the possible benefits from this ethnography. Also discussed in chapter seven were my reflections of ‘things that fell through the cracks’ in this ethnography and suggestions for future research.

The various insights emergent from the integrated feminist postmodern analytic lenses of the MLWNs’ ethnographic data is acknowledged as partial, historical, localised and incomplete. Hence, no theory was proposed. However, each MLWN affirmed the relevance to herself of the respectively revealed insights. The MLWNs’ revealed meanings of their lived experience identified them as legitimate knowledge producers.
Of importance to the wider nursing, health professional arena and social science body of knowledge was the revelation of the MLWNs’ empowering self-managing strategies evident within the cultural construction of the multiplicity of competing and always present disempowering discourses. At the local personal and professional levels, each MLWN’s efforts encompassed a sociopolitical intent; they each sought to have nursing values inscribed as taken-for-granted cultural assumptions within more dominating and disempowering discourses. What was revealed in this thesis, thus, may also benefit nursing leaders within WA, and contribute to the national nursing professional dialogue and agenda related to the attraction and retention of nurses into senior middle-level hierarchical positions in the public health system. This ethnography supported the value and importance for nurses to be the managers of nurses. Also emergent from the MLWNs’ stories and revealed insights was the need for the nursing profession to strongly resist the demise or removal of any senior roles for nurses in the health care system.

In this thesis, the integrated feminist postmodern ethnographic methodology was shown to be an important contribution to nursing research. Through the centring of a feminist oppression narrative with the multiplicity of affirmative postmodernist perspectives, there was the possibility to elicit unique and different meanings of women nurses’ lived experiences. This thesis showed that this methodology has the potential to provide a safe and trusting forum for women nurses to speak for themselves, openly, honestly, freely and of deeply personal and private experiences. What became evident throughout the thesis was that this relatively unfamiliar methodology embraced the value of care which has particular credence to nursing.

The innovative, multi-phased and trifocal analytic process developed to suit the ethnographic research question, aim and objectives was also viewed as an important contribution to the body of nursing knowledge, as well as nursing and critical social science research practices and future research considerations.
Summary Comments on the Chapter

This chapter provided a broad overview of the thesis as a prelude to in-depth discussion and critique of the research process and emergent insights presented in subsequent chapters.

The gap in knowledge within which to situate this multi-sited and methodologically informed feminist postmodern ethnography was revealed by an in-depth review of nursing research and literature in conjunction with the variously substantive national and State reports which related to the Australian and WA nursing profession.

The integration of particular feminist and postmodern theoretical perspectives which informed the research process was introduced, inclusive of the revealing of some of my related assumptions. How these theoretical perspectives informed the development of an innovative multi-phased data analysis approach was also introduced.

Also introduced in this chapter was the notion that this ethnographic thesis revealed a number of insights that indicated varying experiences, located within a number of mobile subjectivity positions, of marginalisation, oppression and empowerment for the participants, in unique and different ways. What also emerged from this thesis were optimistic insights that were worthy of celebration, such as self-managing strategies the MLWNs applied to resist succumbing to alternate oppressive patriarchal discourses, bureaucratic managerialism and medical science. My optimism also focused upon the MLWNs’ local political efforts to breach the hegemonic discourses to inscribe nursing values as integral to the day-to-day taken-for-granted culture within which they practised. The emergent sets of insights from the MLWNs’ experiences, detailed in the thesis, aimed to evoke similar or alternate understandings in the reader but also to deliberately open up critical dialogue within the nursing professional arena. No conclusions were proffered. In this thesis there was no intention to minimise the risks associated with undertaking research in this integrated methodological genre, perspectives that were unfamiliar within nursing research at the time of undertaking this project.
My journey as a nurse researcher undertaking this thesis was among the most privileged learning opportunities I have experienced. I attribute this to the unconditional trust bestowed upon me by each of the women nurse participants.

Presented and discussed in the next chapter are pertinent sociopolitical details related to the broader governmental, health and nursing professional arena that framed the external cultural context of the MLWNs’ practice setting.
Chapter 2.
The MLWNs’ Sociopolitical Cultural Context
**Introduction**

This chapter comprises six inter-related sections as a method to locate the broader sociopolitical cultural context within which MLWNs practised during the ethnography. This chapter is a contextual prelude to the next chapter in which literature and research is critiqued that also revealed a gap in nursing knowledge within which to locate my research interest.

It was my deliberate decision to position this chapter prior to the critique of literature and research. My purpose aimed to assist the flow of reading the thesis. It was important to gain a composite appreciation of the broader sociopolitical context in order to select the appropriate literature for critique and in turn, proceed to my research interest.

Being immersed in the culture of the MLWNs was integral to my ethnographic interest, as method and methodology (Byrne 2001). The environment of my interest was the WA public hospital health arena. More specifically, it was the cultural context of MLWNs who held management and/or clinical specialty positions. This context was assumed to comprise different discourses against and within which was situated the day-to-day working world of these nurses.

In parallel with data collection and data analysis, I developed this chapter as part of the evolving sociopolitical cultural context of the MLWNs. This process aimed to support the postmodern notions of fluidity and flexibility of the MLWNs’ subjectivity positions.

In this chapter I have presented a selective overview of the sociopolitical context of this group of nurses, inclusive of some personal critique. This information formed part of my ethnographic field notes and reflective journal. Thus, information in this chapter is not intended to be a detailed portrayal of all sociopolitical issues and agendas evident at the time of the ethnography.

To locate the overt governmental political context of MLWNs I drew upon national and State reports. These reports, presented in chapter one (Table 1.), related to nursing and health and State government agendas. I also kept pace with media coverage relevant to the health crises within WA public hospitals.
In this chapter and the next chapter, I refer to the various reports as listed in Table 1. ‘Federal and WA State Reports and Decisions Pertinent to the Ethnographic Context’ and which was included in chapter one. These several national and State reports and one national Industrial Relations Commission ruling were relevant to situating the sociopolitical and professional background of the ethnography. These documents assisted my understanding of the external cultural constructions that were present at the time the MLWNs participated in the ethnography.

An overview of the Australian health system and the Australian public hospital system is first presented. Relevant detail about the Australian health workforce, inclusive of the nursing workforce is then outlined. Information is included about the general population of WA and a description of the WA public hospital system. Following this is presented and discussed notable historical political events that related to the WA health system and the nursing profession during the period 2001 to 2007.

Below is a brief introduction to the population within WA at the time of the ethnography.

**Section 1. Western Australian population**

The Department of Health Western Australian (DoHWA 2004) Report of the Health Reform Committee: A Healthy Future for Western Australians reported that in 2004 the Australian population was approximately 20 million. The WA population was around 1.9 million people of whom 1.4 million lived in the metropolitan area (DoHWA 2004). The report indicated that the population growth in WA was expected to rise to 2.4 million by the year 2016 with the greater growth expected in the metropolitan area.

As an overview, the following presents a brief description of the Australian health care system.

**Section 2. Overview of the Australian Health System**

At the time of the ethnography, the Australian health system comprised different sectors, such as: federal (or Commonwealth), State and Territory governments,
departments of Social Security and Veterans’ Affairs and Repatriation, State and Territory instrumentalities, religious and charitable organisations; local governments and private health organisations. Overall, it was considered world-class in its effectiveness and efficiency. ‘Australia consistently ranks in the best performing group of countries for healthy life expectancy and health expenditure per person (WHO 2003)’ (AIHW 2004:5). As noted by D’Avanzo and Giessler (2003) Australia’s national health trends were similar to other developed countries. However, there were a number of significant areas of health management that had not achieved world-class standard, such as for example the Indigenous population. Aboriginal and Torres Strait Islander people were identified as ‘disadvantaged across a range of socioeconomic factors that impact upon health’ (AIHW 2004:195). Sexual assault and abuse, domestic violence, and obesity were health issues that also continued to lag behind. There was a lack of recognition by State and federal governments of the need for adequate funding, as evidenced by non report of these health problems by AIHW (2004).

The Australian Health Minister’s Advisory Council (AHMAC) was a committee of the heads of the Australian Government, State and territory health authorities, and the Australian Government Department of Veteran Affairs (AIHW 2004:6). AHMAC advised the Australian Health Ministers’ Conference on policy, resources and financial issues. The structure of the Australian health care system, although complex, ‘aims to give all Australians – regardless of their personal circumstances – access to adequate health care at an affordable cost or no cost’ (AIHW 2004:6). The Federal Government provided two thirds of funding. State and territory bodies contributed the remainder funding in various ways. The Federal Government contributed funding via two main national subsidy schemes, Medicare and the Pharmaceutical Benefits Scheme. Medicare was institutionalised as the Australian universal system of health insurance (Armstrong 2002). These schemes subsidised payments for services provided by doctors, optometrists and for a high proportion of prescription medications. A highly structured and extensive social welfare system and special arrangements for defense service persons and war veterans further contributed to health funding arrangements. Hospital services were jointly funded by the Australian federal, State and Territory governments (AIHW 2004).
An overview of the Australian public hospital system is presented in the next section.

**Section 3. Australian Public Hospital System**

The Australian public hospital system was an integral component of the Australian health care system. It provided access for people seeking medical attention by way of: ambulance services; their own initiative via emergency departments; or by referral from General Practitioners to specialist doctors. Patients admitted to a public hospital could choose to receive treatment from doctors nominated by the hospital (public patient) free of charge or of their own choice (private patient) and pay for the service. For public patients, medical and hospital service charges were subsidised by Medicare. Private health insurance schemes subsidised the services for private patients (Clinton & Scheiwe 1998). For private patients, the ‘gap’ payment between insurance coverage was partially borne by the individual based upon the type of insurance scheme into which they subscribed. Public hospitals, like other government agencies, were highly regulated, as were the professional health workers employed within the system. Public hospitals were structured as teaching facilities that supported the learning of a wide variety of health workers, inclusive of nurses, doctors, allied health and technician students, international health students and many others. Each public hospital was required to gain accreditation against a national quality set of standards. The Australian Council on Health Standards (ACHS) was an independent, not-for-profit organisation. ACHS provided services to health care organisations, such as the accreditation system through the Evaluation and Quality Improvement Program (EQuIP) (Matthews Pegg Consulting 2003). This was the accreditation program used in WA public hospitals at the time of ethnographic data collection.

The AIHW (2004) reported 9.3% of gross domestic product expenditure nationally was spent on health and a total of $66.6 billion with one third on hospital services.

The performance of the hospital component of the health system had several specific performance indicators that emerged from the 2002 National Health Performance Framework (AIHW 2004). The first three indicators, as listed
below, were used for public acute hospitals and the last was applicable for all hospitals (AIHW 2004:288),

- The cost per [medical] casemix-adjusted separation, an efficiency indicator;
- Waiting times for elective surgery, an access indicator;
- Emergency department waiting times, a responsiveness indicator; and
- Hospital separations with an adverse event, a safety indicator.

These indicators implicated work efficiency and effectiveness outcomes directly upon nurses, especially those in managerial/administrative roles. However, authoritative power to manage against these kinds of national performance indicators was not within the direct job scope for the middle-level nurses within the WA public health system. Other than nursing workforce staff numbers middle-level nurses, those in my ethnography, did not report against these indicators.

What follows is a description of the health workforce within Australia with reference to the WA workforce details.

**Section 4. Health Workforce**

Concern for the current and future capability of the health workforce in Australia came under question in the AIHW report (2004). The key contributing factors were an ageing workforce and population, generally. The AIHW (2004) reported a decrease in nursing workforce from the years of 1996 to 2001 per 100,000 of population (AIHW 2004). In 2001, of the more than 450,000 employees in health occupations more than half were nurses (54%) (AIHW 2004).

In 2001 92% of nurses were women and the proportion of male nurses only - increasing slightly over the previous six years (AIHW 2004). It is worth noting, for my ethnography, from the AIHW report (2004) that nurses in executive and management roles worked much longer hours than other nursing workers.

Prior to the federal election in 2000 Armstrong (2004) highlighted various politicians’ commitment to nursing and the health care within WA. What
Armstrong (2004) emphasised was that in the past ten years, whilst hospital admissions increased by about 44%, nurses per head of population fell - with the resultant increase in nursing workloads. No reference was made of the potential negative impact upon nursing workforce numbers in relation to the persistent fiscal constraints present in the broader arena of the health system.

Jackson, Mannix and Daly (2001) explored some of the critical reasons that were influencing the nursing shortage in Australia. In 2001, nursing as an occupation was also noted to be the smallest in growth in each health occupational group and among the most rapidly aging of the workforce groups (over 45 years) (Jackson, Mannix & Daly 2001). This serious trend for the need for an increased health workforce, especially in the areas of nursing, doctors and other paramedics had been taken up at the national and State levels.

Jones and Cheek’s (2003) interview-based research described the breadth, complexity and unpredictability of nursing practice within Australia. In part, this research informed the National Nursing and Nursing Education Taskforce Report 2002 (N³ET) (Department of Education, Science and Training 2002). In respect to nursing in WA and the need to effectively address the workforce issue, two important reports emerged: The Report of the West Australian Study of Nursing and Midwifery ‘New Vision, New Direction’ (Pinch & Della 2001); and the National Nursing and Nursing Education Taskforce Report 2002 (N³ET). Neither of these reports referred to issues for the nursing profession of the emergent rational-economic changes embedded within the Australian health system. However, these two reports were taken up by leaders in the WA nursing profession, led by the OCNO, DoHWA, and the CEO, NBWA. Some of their initiatives to address these reports are discussed throughout the next few sections.

As my ethnography was situated within the WA public hospital setting, the following section includes relevant detail about this setting.

Section 5. Western Australian Public Hospitals
In 2004, from the Report of the Health Reform Committee of March 2004 (DoHWA 2004) there were thirteen Perth metropolitan public hospitals with
varying scope of health services. Below, are details which identify the Perth metropolitan hospitals’ status as either tertiary or secondary hospitals at the time of the ethnography (Table 4. Perth, WA, Metropolitan Public General & Mental Health Hospitals in 2004). Tertiary hospitals in WA had formal teaching responsibilities for the health professions. Secondary hospitals were very important in supporting communities’ health needs, inclusive of various levels of student health professional teaching and clinical practicum. The location within which I undertook the ethnography was two of these WA public hospitals.

Table 4. Perth, WA, Metropolitan Public General and Mental Health Hospitals in 2004.

<table>
<thead>
<tr>
<th>Type of Hospital</th>
<th>Name of Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tertiary Hospitals</td>
<td>Royal Perth Hospital (including Royal Perth Rehabilitation Hospital)</td>
</tr>
<tr>
<td>(n = 5)</td>
<td>Sir Charles Gairdner Hospital</td>
</tr>
<tr>
<td></td>
<td>Fremantle Hospital (including Woodside Maternity Hospital)</td>
</tr>
<tr>
<td></td>
<td>King Edward Memorial Hospital for Women</td>
</tr>
<tr>
<td></td>
<td>Princess Margaret Hospital for Children</td>
</tr>
<tr>
<td></td>
<td>Armadale-Kelmscott Memorial Hospital</td>
</tr>
<tr>
<td></td>
<td>Bentley Hospital</td>
</tr>
<tr>
<td></td>
<td>Graylands Selby-Lemnos Hospital</td>
</tr>
<tr>
<td></td>
<td>Kalamunda Hospital</td>
</tr>
<tr>
<td></td>
<td>Osborne Park Hospital</td>
</tr>
<tr>
<td></td>
<td>Rockingham/Kwinana Hospital</td>
</tr>
<tr>
<td></td>
<td>Swan District Hospital</td>
</tr>
<tr>
<td></td>
<td>Alma Street Centre</td>
</tr>
<tr>
<td>Secondary Hospitals</td>
<td></td>
</tr>
<tr>
<td>(n = 8)</td>
<td></td>
</tr>
</tbody>
</table>

The following section chronologically incorporates sociopolitical and governmental background information which I had recorded as part of my ethnographic field notes. The information presented is not an exhaustive account of all issues to which the MLWNs may have been exposed or involved in throughout the ethnography.

Section 6. Notable Western Australian Health System Political Events pertinent to the Ethnography

2001 (commencement of ethnography)
In 2001, The Report of the West Australian Study of Nursing and Midwifery ‘New Vision, New Direction’ (Pinch & Della 2001) was launched. It was a strategic framework for the nursing and midwifery profession. This report had
sought extensive consultation from numerous representatives from WA nursing professionals and other health professionals. The report focused upon internal-to-nursing issues. However, there was no inclusion of external factors that were impacting negatively upon the profession. Notwithstanding this exclusion, the five key dimensions emergent from the report had important components including: ‘career progression, professional staff development, a scope of nursing practice decision-making framework, and a workforce component including graduate transitions, refresher and re-registration programs’ (Pinch & Della 2001:4). Overall, 61 recommendations emerged from the report’s consultative study. Integral within this report was the following proposed vision for the WA nursing and midwifery professions,

Nurses and midwives practice with expertise which earn them trust and respect from the community. Their future role will be enhanced by a decision-making framework that focuses on achieving health outcomes. That framework will enable nurses and midwives to use their professional judgments within specific care contexts that allow them to determine their practice based upon agreed principles and competencies with the support from their peers.

Nurses and midwives will increasingly become the principal care coordinators and take on advanced and enhanced roles that are based on community needs. These needs will include access to high quality health care provided by highly skilled nurses and midwives who will be equal members of the comprehensive health team. Importantly the value of caring will be maintained in all aspects of nursing and midwifery (Pinch & Della 2001:7 emphasis added).

From this nursing vision, several features were relevant to my ethnography: care contexts, care coordinators, equal members of the comprehensive health team, and the value of caring. The notion of care, from this vision statement, was asserted to be implicitly integral to nursing practice.

Of particular note for my ethnography were three other features from the 2001 Report of the West Australian Study of Nursing and Midwifery ‘New Vision, New
Direction’ (Pinch & Della 2001). Firstly, it was a promising and optimistic vision. A second factor of particular interest to the ethnography related to the poor image and status of the nursing profession. The recommendation from this finding was that ‘nursing and midwifery leaders must ensure a cultural change occurs that empowers nurses and midwives to value each other within the profession’ (Pinch & Della 2001:27 emphasis added). Empowerment, within this report’s leadership concept related to: ‘promoting leadership in nursing and midwifery [which] involves influencing the culture of the profession so that nurses and midwives identify the leadership potential in their roles’ (Pinch & Della 2001:49 emphasis added). The third relevant factor was that ‘nursing and midwifery leaders need to be visible and provide a strong voice for nursing on professional issues and decision-making bodies’ (Pinch & Della 2001:49 emphasis added). My localised research interest related to gaining understanding of the culture within which MLWNs practised in WA public hospitals which may or may not have constrained their experience of empowerment. Further, my research interest was to foreground the participants’ voices.

2002
In 2002 the Australian Labor party won the WA State election. From informal conversation with several leaders of nursing in WA (names withheld to protect identity) I was informed that the public hospitals’ annual increase overspend of 5-8% in health services was mostly attributed to increased nursing workforce costs. The new Labor State government also began to re-centralise the public health service budget management by firstly disbanding the Hospital Management Boards. In the restructure, key executive positions were re-titled to reflect changes in function and accountability. This restructure also changed the role and functions of some public hospitals’ Directors of Nursing (DON). This change included broader nursing service management functions across a number of metropolitan public hospitals and nursing services within a geographical area. Hence their new title became Area Directors of Nursing Services (ADNS). This change in management structure and function also altered the power/responsibilities of the DONs in the smaller public metropolitan and regional public hospitals. The changes, however, also included a reduction
in the number of nurses in leadership positions within the State health care system.

Changes to other State government agencies were also planned by the Labor State government. While I was in the role of General Manager in one of Perth’s Technical and Further Education colleges, we were notified of the State government’s decision to re-centralise all State government's corporate service functions. The intent was to create a common government-based Corporate Services Business Systems for recruitment and selection of staff and other common functions (Department of the Premier and Cabinet Western Australia 2005). This change would involve all governmental departments, inclusive of public hospitals. One impact would be that all appointments, as well as nursing appointments, would be undertaken at a location away from the actual service delivery area. There appeared to be no consideration by the government of the potential loss of the personal connectedness associated with the recruitment process. Recruitment, from my experience, is a process that also encompasses marketing the workplace culture to prospective employees.

2003
In 2003 a joint initiative between NBWA and the OCNO, DoHWA, was the establishment of the Clinical Education for the Future Project (CEFF). This project aimed to address the WA nursing workforce problems in relation to undergraduate and postgraduate clinical education needs. The intent was to ‘identify and facilitate the evaluation, where necessary, of new models and methods of clinical education that are responsive to anticipated future trends in nursing and health care’ (NBWA Annual Report 2003-4:8). The project purpose was determined as a consequence of increased patient acuity, greater nursing workloads, larger numbers of health discipline students’ practicum needs, and clinical supervision demands. It was also because ‘not all nurses enjoy or feel prepared to teach’ (Watts 2005:6). For about 12 months, I was privileged to be a member of the project team.

At this time also, the DoHWA required that public health service nurses be hired via a newly established DoHWA funded organisation, NurseWest, a specifically created nursing staff ‘pool’ (www.nursing.health.wa.gov/nursewest/index.cfm).
NurseWest was one strategy by which the State government aimed to reign in the health budget over-expenditure. The NurseWest service also aimed to improve nursing resource utilisation in the public hospitals. The strategy aimed to reverse the high cost for public hospitals of hiring agency nurses and to encourage these nurses into the public health system. In conjunction with this recruitment policy change was the introduction by the OCNO, DoHWA, of a marketing strategy which aimed to improve the professional profile of nursing in WA. The principal public marketing campaign was the widespread challenge of ‘Are You Good Enough To Be A Nurse?’

The OCNO, DoHWA, in collaboration with CEO, NBWA, also established a number of forums (OCNO, DoHWA 2006) to which public sector senior nurses from community nursing, midwifery, acute care, education providers, and others were invited to engage in professional dialogue about State and national nursing professional issues. Guests to these meetings included a number of high profile Australian and international nursing leaders. These meetings also provided opportunity for the senior nurses to advise and make recommendations to the OCNO DoHWA and CEO, NBWA. The meetings also aimed to empower the WA nursing leaders and to create a framework for a collaborative voice in decision-making at State and national levels. My participation in these forums provided important professional development opportunities.

Another initiative commenced by the OCNO, DoHWA, was to sponsor, initially, thirty junior registered nurses and middle-level nurses to undertake a postgraduate university-based business course, ‘Vital Leadership’. This course also offered an internship in a non-health environment and for students to be mentored by an experienced business person (DoHWA retrieved 28.09.2005). The intent of this project was to remodel nursing practice and management from task-oriented and transactional leadership to that of transformational leadership.

The chair of N³ET, Moyes (web download 23.10.2005), explained that in 2003 the Australian Government Ministers for Education and Health announced the establishment of a National Nursing and Nursing Education Taskforce (N³ET).
The N³ET was established to implement recommendations of *Our Duty of Care Report* (Department of Education, Science and Training 2002), from the report of the National Review of Nursing Education 2002. Moyes further noted that *Our Duty of Care Report* identified the ‘need for a national focus, a coherent voice on nursing issues, nursing leadership and recognition and affirmation of nurses’ (Department of Education, Science and Training 2002:108). To address these national issues, the OCNO, DoHWA, (2005) established another series of forums that sought to generate discussion among a variety of nursing leaders and stakeholders about the report’s recommendations, provide feedback to the national taskforce, and create strategies suitable for WA to implement. I was privileged to be invited to participate in each of these forums.

**2004**

2004 was a momentous year for the WA nursing profession. The WA State government endorsed changes to the Nurses Amendment Act 2003. This change permitted specially qualified nurses to become Nurse Practitioners. It was not until 2006, however, that National Competencies Standards for the Nurse Practitioner were launched in WA (Onboard 2006:9). These postgraduate qualified Nurse Practitioners were legislated to have limited pharmaceutical prescribing rights and nurse-initiated investigation ordering rights within specific areas of specialty nursing. This was a significant legislated extension in the scope of nursing practice. WA followed the NSW Nurses Board’s efforts to win a long and arduous battle for nursing practice against the highly resistant Australian medical fraternity (Chiarella 1998). Chiarella (1998:frame 3) was the principal advocate for the role of the Nurse Practitioner within Australia. She highlighted that the focus of nursing was on the lived experience of the patient alleviating the ‘here and now’ and that some functions may overlap that of medicine but was not a takeover of medicine (Chiarella 1998:frame 3). The Nurse Practitioner legislation in WA, and other Australian States, was a major breakthrough for the legitimisation of the expertise of nurses in their own right. It was a further demonstration by Australian nursing professionals of their concern for meeting patient care needs in a safe and effective way.

In March 2003 the WA State government appointed the Health Reform Committee ‘to develop a vision for the Western Australian health system while
ensuring that the growth of the health budget was sustainable’ (DoHWA 2004:v). Like other Western countries, WA was faced with increasing demand and challenges to sustain its high standard of quality health services (DoHWA 2004). The report was published in March 2004 and was also referred to as the Reid Report (Professor Michael Reid – Chair). In particular, the Health Reform Committee commented that:

[W]hat is clear is that incremental reform is no longer the pathway to a financially sustainable vision for Western Australia. A fundamental reprioritisation of the public health system is needed, and should be carried out over the next decade, in a systematic and integrated way. (DoHWA 2004:v)

Of interest to my ethnography from the Report of the Health Reform Committee (DoHWA 2004) was one recommendation as listed in Table 5. ‘Selected Recommendation from the DoHWA (2004) Report of the Health Reform Committee: A Healthy Future for Western Australians’. The potential impact of implementation of this proposed restructure would be upon the DONs of the metropolitan hospitals and thus, secondarily, upon the relationship between the outgoing and new incoming DONs and their nurses in middle level positions.


<table>
<thead>
<tr>
<th>Recommendation number</th>
<th>Detail of recommendation</th>
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| Recommendation 69 (DoHWA 2004:xx) | The Area Health Service structure should be modified as soon as possible to include only three metropolitan Area Health Services:  
• A North Metropolitan Area Health Service responsible for the health needs of the population north of the Swan River.  
• A South Metropolitan Area Health Service responsible for the health needs of the population south of the Swan River  
• A Women’s and Children’s Health Service. |

The Report of the Health Reform Committee (DoHWA 2004) also made note of the low workplace morale. It also referred to the establishment of ‘Nurses Hours Per Patient Day (2001)’ (NHpPD) model, as a ruling by the Australian Industrial Commission. This ruling was a significant breakthrough by the Australian
Nursing Federation and other professional parties that focused on the introduction of more appropriate resources to meet estimated nursing workloads in specialist practice areas across the WA public health sector. The model was based upon several criteria: clinical assessment of patient needs; the demands of the environment such as ward layout; statutory obligations including workplace safety and health legislation; the requirements of nurse regulatory legislation and professional standards; and reasonable workloads (Nurses (WA Government Health Services) Exceptional Matters Order C2001/1910 11.02.02). The significance of this Industrial Relations Commission ruling for WA was a marked increase in nursing establishment numbers in many nursing practice settings. Mantell, Twigg and Kelly (2005:abstract) noted the benefits of this NHpPD model as providing ‘a cost-effective mechanism to assist in addressing nurses’ workload with a definitive impact on patient care provision’. In relation to this ruling, Illiffe and Blake (2004) noted that the WA industrial instrument while different to that in Victoria was used at the ward or unit level and not at executive nursing level. The 9th Nursing Workload Report (DoHWA 2006) demonstrated that across WA metropolitan and rural hospital patient care areas for the period July 2005 – June 2006 75.7% (n=165) of reported ward areas were on or above set NHpPD targets.

2005

In early 2005 the NBWA (2005) launched one of its most profoundly positive initiatives: Scope of Nursing Practice and Decision Making Framework (SONP DMF). Modeled along similar concepts to that of Queensland Nursing Council’s 1998 SONP DMF, the WA framework broadened the practice realm for registered and enrolled nurses. In particular, the model encompassed a significant increased level of self-accountability on the individual nurse. The level of self-surveillance evident within the WA SONP DMF model dramatically and positively impacted upon nursing decision making. The model provided guidelines for clinical decision-making, delegation of nursing and other patient care activities, and expansion of nursing practice. In contrast to other Australian States and Territories, the model used in WA and Queensland aimed to empower the nurse to undertake nursing professional activities never before considered appropriate to nursing practice. The NBWA framework was made available to the national N³ET committee for consideration of Recommendation
4 of the *Our Duty of Care* report which sought to develop a Nationally Consistent Scope of Practice. No final national outcome was evident in 2007.

In 2005 the WA public hospitals were in extreme financial difficulty which had previously been inadequately addressed at State and national levels (Drummond & O'Leary September 21, 2005). However, in late 2005, as a consequence of a booming WA economy, the Labor State government’s Minister for Health announced a boost to health facilities improvement. This decision was based upon its 10-year health blueprint with $890million capital works program for hospitals across the State. The aim was to implement the recommendations of the Reid Report (DoHWA 2004). In addition to the construction of a new metropolitan tertiary hospital and as well as making improvements to existing facilities and reconfiguring some hospitals’ services, the Minister for Health also affirmed recruitment of an extra 1200 extra nurses. The additional recruitment was part of the government’s first term commitment. It was committed to hire an additional 800 full-time nurses in the second term to meet the needs of the health reform changes (Department of the Premier and Cabinet Western Australia 2005). What was missing from this announcement was a solution to fund WA universities and Technical and Further Education Colleges to accommodate the needed increase in graduate nurse numbers. Nor was there recognition of the critical problem related to clinical placement, as had been identified by the Clinical Education for the Future Project (CEFF) (NBWA Annual Report 2003-4).

**2006 (completion of data analysis)**

In 2006 an emergent concern about generic managers controlling nursing practice was noted in *The Western Nurse*, the July/August edition (No author, Nurse West 2006:19), the WA branch of the Australian Nursing Federation publication. The un-authored article noted that a recent introduction of non-nurse ward managers in a large health service in NSW formed part of a plan ‘to reduce the managerial input of the largest professional group in its employ’ (The Western Nurse 2006:19). It had even started offering redundancies to senior nurses because of the abolition of nurse management positions. The role change meant that nurses would only be responsible for patient flow and bed occupancy. Furthermore, they would only have an advisory function ‘on the
funding required to pay for the services and nurses required to safely staff those beds’ (The Western Nurse 2006:19). This extraordinary situation was also reported in Orrock and Lawler’s (2006) research.

Orrock and Lawler (2006) claimed that the NSW reforms dramatically marginalised nursing leadership and management. The change shifted ‘focus from patient care delivery functions to the structural, financial and strategic planning aspects of the organisation’ (Orrock & Lawler 2006:frame 2). This ‘care-re-engineering’ was asserted by Orrock and Lawler (2006:frame 2) to have had marked negative impact upon nursing recruitment and retention. For example, part of their initial data analysis also revealed that participants felt like they were practicing within a culture of domestic violence (Orrock & Lawler 2006).

The existence of a nursing hierarchy within the hospital structure was an historical feature. It was linked with the success in retaining the direction and monitoring for nurses within health care organisations and was closely linked with a nurse’s professional identity (Causer & Exworthy 1999). Was the Australian nursing profession at another cross-road where advances in nursing practice, education and research were emerging but nursing high level decisions were being made by non-nurses in relation to nursing service delivery management? Would the emerging evidence of the marginalisation of executive nurses, as reported in NSW from managing the nursing workforce become a reality within WA?

At the time of the nursing leadership restructuring in NSW, in WA Jones (2006) surveyed nurses to assess the wellbeing of the WA nursing profession. Of note, respondents rated the importance of their work less than the prestige, status or income of their work. These findings were consistent with the Report of the West Australian Study of Nursing and Midwifery ‘New Vision, New Direction’ 2001 (Pinch & Della 2001), and the National Nursing and Nursing Education Taskforce Report 2002 (N³ET) (Department of Education, Science and Training 2002). However, in critiquing Jones’ (2006) study, what was unsaid was that there had been little improvement for nurses in the intervening years between Jones’ (2006) survey and the two government reports. No reasons were
proffered as to why WA nurses perceived their work was not important. Nor was it revealed what nursing leadership support was available to the nurses to alleviate their tensions. The impression from this report was not one of optimism for the wellbeing of nurses in WA.

2007

In the latter part of 2007 I was preparing my final draft for the thesis. Several particularly pertinent media headlines added further to the sociopolitical context for nurses in WA and for the Australian nursing profession.

The first issue made the frontpage of the West Australian newspaper which claimed ‘Perth hospitals were in meltdown’ (O’Leary 2007:1). This article referred to 170 patients who were unable to access the public hospitals’ emergency departments with many waiting for medical attention on ambulance trolleys. It was noted that the State government attributed the crisis to a lack of adequate hospital staff and aged care places in the community. Guest (2007:1) also hit the headlines with her article highlighting the impact upon WA public hospitals of the shortage of nursing staff. Guest told of the need by one Perth tertiary hospital’s need to write an apology to wait-listed people ‘pleading for tolerance and conceding that services may suffer as a result of its inability to recruit enough nurses’ (Guest 2007:1).

A second issue related to a national newspaper, The Australian, frontpage headlines which revealed one of the Prime Minister’s federal election campaign promises ‘Nursing to lead PM’s fightback’ (Shanahan & Karvelas 2007:1). While the federal government’s interest to support nursing workforce issues was to be commended, the initiative may have a reversed negative impact. The Prime Minister, John Howard, was claimed to propose a dramatic ‘overhaul [to] nursing education, with a $170 million plan to build 25 privately operated nursing schools in hospitals’ (Shanahan & Karvelas 2007:1). The intent indicated an increased number of nurses by 500 per year by way of re-introducing hospital based training. The media author claimed that ‘doctors, hospital administrators and private hospital employers will have input into the training programs to ensure the nurses emerge with skills sought by their industry’ (Shanahan & Karvelas 2007:1). This startling federal election proposal,
if enacted, had the possibility to instantly deconstruct the nursing profession’s efforts over the past twenty-five years to reverse the historical subjugation of nursing education. No other professional group was targeted to be returned into subservient learning positions.

In the midst of the federal election campaign health was identified as a major point of difference between the Liberal and Labor political parties (Kelly 2007:19). The Opposition leader, Kevin Rudd, was noted to have no clear solution to the Australia-wide nursing workforce crisis. However, he asserted that a Labor government, if elected, would plan for a financial takeover of every State’s public hospitals if ‘the States did not co-operate in reforms’ (Steketee 2007:19). What value this would have to resolving health professional workforce issues was not made clear.

In November 2007 the Australian public overwhelmingly elected Labor into federal government.

From the various media coverage related to nursing issues, especially at the WA level throughout the ethnography, the principal rebuttals were made by the Australian Nursing Federation State secretary. Being government employees may have been the reason for the absence of other nursing leaders’ voices in the media! However, there were uncertainties of what an incoming Labor government will achieve for the Australian nursing profession. Thus, it would be critical that nurse leaders focused their voice and spoke out loudly to ensure the achievements of the nursing profession over the past thirty years were not so subsumed in economic rationalism that would result in a return to the oppressive era of non-tertiary education.

**Summary Comments on the Chapter**

In this chapter I presented an overview of various sociopolitical and professional nursing issues as these framed the broader cultural context of the MLWNs’ practice setting. Emergent from an understanding and critique of this background was a partial space within which to locate and progress my research interest.
During the period of this ethnography the Australian nursing profession experienced a mix of historical breakthroughs. There was new legislation for the Nurse Practitioner role. The release of important State and federal investigative nursing and midwifery reports resulted in considerable national nursing profession action. With the introduction of the new scope of nursing practice guidelines in various States, including WA, nurses gained enhanced practice-based empowerment. Further, there were considerable government recognition and intervention efforts that sought to foster attraction and retention of nurses into the public health system. Whilst these kinds of breakthroughs were beneficial to the nursing profession there were also persistent subjugating actions at the local WA State government levels. There was restructuring at executive public hospital level which presented as instability and uncertainty for the future leadership of nursing. Further, it was reported that WA nurses perceived their status and prestige as poor in relation to the importance they placed upon the nature of their work (Jones 2006). More disturbingly, in 2007, the federal government’s proposed election initiative to re-instate hospital based nursing training and the opposition leader’s lack of clarity to resolve the critical nursing workforce shortage could be viewed as an unconsidered re-subjugating of nurses.

The uncertainty of the future for nurses to manage nurses (Orrock & Lawler 2006) emerged as a concern. This was a consequence of NSW government decision to displace executive nurses for non-nurses in some health service delivery areas. This kind of marginalisation of nursing leadership roles was brought to the attention of the Australian nursing profession thirty years earlier by Ashley (1976 in Kagan 2006:317). Her concern had been based upon her feminist nursing research findings from which she urged that nurses must ‘retain control and power over their professional practice and providence’.

Recent restructure and diminution of nursing leadership roles in NSW, was an alarming event. My research interest incorporated an aim to valorise the importance of nurses in senior health organisation positions. The events in NSW, as one example, indicated a gap in the Australian nursing research field. Further, my research interest aimed to contribute to contemporary dialogue within the WA and national nursing profession. My interest was to foreground
the voices of the MLWNs who were positioned within the confluence of public hospitals’ corporate business agenda and their professional nursing responsibilities. My interest was also to centre optimistic insights of the practical ways MLWNs self-managed within their complex cultural contexts.

Within the context and timing of my ethnography the State and national sociopolitical nursing profession-related events were assumed to have impacted differently upon nurses practicing in middle-level roles within the public hospital system.

The sociopolitical context as presented in this chapter aimed to provide a backdrop that surrounded each MLWN. This contextual frame was also a lead into the next chapter, chapter three, where literature and research are critiqued.
Chapter 3.
Discourses Impacting Upon
Middle-Level Women Nurses
Introduction
Australian and international research literature and scholarly works generally lacked optimism in relation to those nurses whose employment positions formally involved management and/or clinical specialisation. Alarmingly, similar oppressive issues were identified for nurses in executive hospital positions. This chapter will demonstrate the plight of senior nurse managers in health organisations, and nurses who have held clinical nurse specialty positions. In particular, the chapter will reveal that nurses have remained undervalued, under-supported, and are of low status. Furthermore, they were found to be powerless to influence health care organisational or system policy and practices.

My focus in searching the literature for the gap in knowledge within which to locate my research interest was specifically directed toward nurses in the middle-level of public hospital organisational structures. It was to the various discourses surrounding and potentially impacting upon this group of nurses that I concentrated my attention. My interest was also directed toward reviewing nursing research which foregrounded women nurses’ voices. I sought to uncover literature and research that explored and critiqued common, unique and different lived experiences of nurses whose roles were different but whose hierarchical position in hospitals was similar. Further, I sought to identify publications that celebrated nurses’ personal and professional endeavours, those that showed resistance to domination and/or revealed emancipatory practices.

My attention was drawn to the January 2006 issue of the Journal of Nursing Management. A respected resource for contemporary nursing practice, this issue specifically examined current research and scholarly papers related to middle level nurse managers. Hewison (2006:frame 2) claimed in the editorial that ‘there is still a dearth of evidence concerning the nature of middle management and nursing’. Further, Hewison (2006:frame 3) asserted that this level of nurse had been somewhat ‘hidden’ and the intent was to uncover their contribution within health care organisations. Forbes and Hallier (2006) also emphasised that little attempt had been made to understand the impact on
professional-management relations with individual health professionals. Their research with individual doctors in Britain was among the few published to date.

In contrast, in 2004 the DoHWA, in collaboration with the School of Nursing and Midwifery, Curtin University of Technology and the School of Nursing and Public Health, Edith Cowan University, published the first two *The Nurse Practitioner Series* (DoHWA 2004a, b). This series celebrated the research achievements of newly qualified Nurse Practitioners in WA and New Zealand. Literature showed that the emergent status for higher degree qualified clinical nurses had the potential to enhance the legitimation of clinical nursing knowledge expertise.

What emerged from my literature review was that in the interstices of nursing research was an opportunity within which my research interest could be located. In addition, there was opportunity for research with an optimistic intent for women nurses to speak for themselves. My interest in undertaking the literature and research review was also to affirm that my proposed research would contribute to the international body of nursing knowledge.

My initial thinking was directed to understanding what research had already been undertaken. Of specific interest were the following:

- What was being said about nurses who practised in middle-level health organisations;
- What experiences were being reported;
- How were the experiences of this group of nurses’ being explored;
- What discourses were impacting upon them; and
- How was the education literature portraying this group of nurses?

Ethnographic accounts with middle-level experienced women nurses framed within a feminist oppression narrative and integrated with postmodern perspectives were identified to be a mostly unexplored research terrain. Few studies were identified that located nursing workplace related issues within competing cultural discourses. The centring of nurses’ voices in nursing research was identified as an increasingly legitimate way for nursing knowledge
to be revealed and disseminated. Thus, nursing research within the critical feminist postmodern genre was identified as an emergent valuable source for nursing knowledge production and legitimation. These methodological perspectives, that informed and framed my ethnography are detailed in the next chapter.

The scope of discourses evident in nursing research that related to my research interest was found to be dominated by the positivist authorial voice. There was also considerable research which had applied grounded theory and phenomenological qualitative methodologies, yet, there were limited but emergent publications that applied integrated feminist postmodern methodologies. The research that did apply this methodology was predominantly Australian based. No research was identified that foregrounded middle-level women nurses' practical empowerment strategies. Further, no research was located that critiqued, in depth, the multiplicity of discourses within which this level of nurse practised. In addition, a plethora of popular literature was available about empowerment models for organisational culture, leadership and management practices. However, this material was shown to embed patriarchal theory and practice with an almost absent inclusion of reality based experiences, and was less inclusive of women’s voices.

Aligning with Roberts and Taylor’s (2002b:493) recommendations this chapter is constructed as ‘an amalgam of the literature presented in [my] proposal, plus that which has come to light since the project began’. To ensure my research interest and endeavour would be unique and contribute to the body of nursing knowledge I searched widely through various electronic search engines and other reference sources using key terms inherent in my research focus, question, aim and objectives.

Table 6. ‘Literature and Research Sources’ has listed the various search engines and journals that I drew upon. In particular, I sought to access full text publications and not just that of abstracts. I also drew upon education publications related to management and leadership that either I had used in my academic teaching with nurses or texts typically recommended in nursing undergraduate and postgraduate studies. The various nursing management
and leadership education publications that I drew upon are also listed in this table. These are critiqued in section two of this chapter. I sought to locate research and educational publications primarily from the 1990s to 2007.

Table 6. Literature and Research Sources.

<table>
<thead>
<tr>
<th>Literature and Research Source</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic Search Engine</td>
<td>Australian Digital Thesis Program</td>
</tr>
<tr>
<td></td>
<td>Blackwell Synergy</td>
</tr>
<tr>
<td></td>
<td>Google Scholar</td>
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<tr>
<td></td>
<td>InfoTrac</td>
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<td></td>
<td>Ovid</td>
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<td></td>
<td>Proquest</td>
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<td></td>
<td>PubMed</td>
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<td></td>
<td>Southern Cross University Expanded Academic</td>
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<tr>
<td>Nursing Journals</td>
<td>Advances in Nursing Science</td>
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<tr>
<td></td>
<td>Collegian</td>
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<td></td>
<td>Contemporary Nurse</td>
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<td></td>
<td>Journal of Advanced Nursing</td>
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<td></td>
<td>Journal of Nursing Management</td>
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<td>Nursing Administration</td>
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<td></td>
<td>Nursing Forum</td>
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<td></td>
<td>Nursing Inquiry</td>
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<td></td>
<td>Nursing Outlook</td>
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<tr>
<td>Nursing Management/Leadership Texts</td>
<td>Daly, Speedy &amp; Jackson (2004)</td>
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<tr>
<td></td>
<td>Lawson, Rotem &amp; Bates (1996)</td>
</tr>
<tr>
<td></td>
<td>Marquis &amp; Huston (2003), (2006)</td>
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<tr>
<td></td>
<td>Porter-O’Grady (1992)</td>
</tr>
<tr>
<td></td>
<td>Quinn, Faerman, Thompson &amp; McGrath (1996)</td>
</tr>
<tr>
<td></td>
<td>Seng, Kleiner, Roberts, Ross &amp; Smith (1994)</td>
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<tr>
<td></td>
<td>Sullivan &amp; Decker (1997)</td>
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<tr>
<td></td>
<td>Swansburg (1996)</td>
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<td></td>
<td>Yoder-Wise (1999)</td>
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</table>

Thus, in this chapter I present an array of research and literature. It was focused on nurses and nursing and related to a number of discourses, as presented below, in no particular order, in Table 7. ‘Scope of Discourses Reviewed’. The review also covers other different aspects of the nursing experience that were generally linked with nurses employed in middle-level positions of health organisations.
Table 7. Scope of Discourses Reviewed.

<table>
<thead>
<tr>
<th>Discourses reviewed</th>
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<tbody>
<tr>
<td>• Care As A Nursing Value</td>
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<tr>
<td>• Clinical Nursing</td>
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<tr>
<td>• Health Economics</td>
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<tr>
<td>• Horizontal Violence</td>
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<tr>
<td>• Job Satisfaction</td>
</tr>
<tr>
<td>• Leadership Skills</td>
</tr>
<tr>
<td>• Management Practices</td>
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<tr>
<td>• Managerialism</td>
</tr>
<tr>
<td>• Models Of Practice</td>
</tr>
<tr>
<td>• Nursing Education</td>
</tr>
<tr>
<td>• Nursing Knowledge</td>
</tr>
<tr>
<td>• Nursing Economics</td>
</tr>
<tr>
<td>• Oppression of Nurses</td>
</tr>
<tr>
<td>• Recruitment and Retention</td>
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<tr>
<td>• Workplace Culture</td>
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<tr>
<td>• Vulnerability</td>
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</tbody>
</table>

The literature I reviewed showcased knowledge of the problems confronting the nursing profession. It also highlighted the persistent marginalisation of nurses and nursing knowledge. For example, the burgeoning discourse of managerialism within the cultural context of health care organisations and practices emerged from the literature and research as a more dominating discourse. Managerialism was found more dominating than that of the traditionally patriarchal medical discourse for nurses located in higher levels of hierarchic organisational settings. These issues are critiqued in this chapter.

Abundant literature was also available from nursing, health professional and generic business education disciplines that proffered prescriptive guides of ‘how to’, ‘why’ and theory. The focus of these publications was nurses and other people whose work was located in the middle-level hierarchy of health organisations. I continued to be an advocate of such texts as extremely valuable contributions to nursing education. However, there persisted in such texts, and as critiqued in this chapter, patriarchal overtones of authorial righteousness with extremely limited inclusion of the voices and knowledge of the reality of the lived experience of women or nurses in such work roles. Theory predominated over practice.
My approach to this chapter was also influenced by Falk Rafael (1997). From a postmodern perspective, Falk Rafael (1997:35) recommended reviewing literature to locate ‘who decides what counts as knowledge, how power is produced and reproduced’. Drawing from Weedon’s feminist interest, Falk Rafael (1997:35) also urged the need to review ‘whose interests are silenced, marginalized or excluded’ and how open it is to transformative possibilities. What I have demonstrated in this chapter, therefore, was the scarcity of research and literature that ‘tells it as it is’, that is, from the actual voices of middle-level woman nurses. What became apparent from the literature and research review was a critical need to foreground the voices of women nurses. Such an approach would have the potential to celebrate the legitimacy of their knowledge, as women’s ways of knowing. This feature was integral to my research interest.

This chapter is structured into six sections. Each section represents selectively titled discourses that encompassed related literature and research. Collectively, within the interstices of my critique of these discourses I believed there was space within which to locate my research interest.

Section one foregrounds a number of Australian nursing qualitative research publications that made important positive contributions to the way I viewed my nursing research interest. Section two explores a number of issues related to the struggling status of nursing. It also highlights research which demonstrated the continuing subjugation of nursing knowledge. The emergent validation of nursing clinical practice expertise is critiqued in this section. Section three incorporates critique of two discourses. The notions of healthy nursing practice workplace culture are first critiqued. This critique incorporated research and literature related to empowering strategies of mentorship and healthy workplace cultures. This is followed by a critique of the particularly disturbing literature related to nurse-nurse violence. The nurse-nurse violence discourse was increasingly evident within the cultural context of the nursing profession. Section four reviews and critiques literature and research that focused upon nurses in executive positions. What is highlighted in this section was the lack of consistency evident in the way nurses in these leadership positions functioned and the disempowerment they experienced. Finally, section five critiques the
emergent new dominant patriarchal discourse of managerialism, or health economics, and its impact upon nurses and nursing practice.

At the beginning of each section I include a table that lists the respective author’s literature and/or research critiqued in that section. The list is structured in date order rather than as in the sequence by which the work is critiqued.

From a postmodern perspective I acknowledge that other research and scholarly works could have been reviewed and included in this chapter. Other publications may have provided a different and alternate reading and critique.

I commenced my literature and research critique in section one below with a foregrounding of several pertinent Australian qualitative nursing research. These research projects assisted in affirming that my methodological interest could reveal valuable unique, local and particularised nursing knowledge.

Section 1. Foregrounding Specific Australian Nursing Research that Influenced the Ethnography.

Introduction to this section
In this section I critique a number of nursing related Australian studies that had particular relevance to my research topic, methodology and methods. These studies demonstrated a partial space within which my research interest could be locally contextualised. In particular, I drew upon specific Australian nursing qualitative research that contributed significantly to the body of professional nursing knowledge by challenging the status quo of the subjugation of nurses and nursing knowledge.

Table 8. ‘Examples of Australian Qualitative Nursing Research Influential to the Ethnography’ lists particular Australian researchers. All but one researcher was a nurse (A. F. Street 1992). These scholars contributed significantly to the development of the focus of my research interest. These research projects also contributed to the substantial clarity that Australian nurses have been historically subordinated to other dominant patriarchal social constructs, such as medicine, health administrators and the law. Their qualitative studies
disrupted the status quo and the taken-for-granted discourses of nursing. The studies incorporated the personal words and stories of their participants, or their interpretation of nurses’ experiences, and themselves as researchers. They aimed to enhance the conscious awareness of the oppressive context of nurses’ practice.

Table 8. Examples of Australian Qualitative Nursing Research Influential to the Ethnography.

<table>
<thead>
<tr>
<th>Year</th>
<th>Researcher</th>
<th>Methodology/Method</th>
<th>Nursing Research Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>Irurita</td>
<td>Grounded theory - sensemaking paradigm</td>
<td>Optimising Theory of Nursing Leadership</td>
</tr>
<tr>
<td>1991</td>
<td>Lawler</td>
<td>Grounded theory &amp; ethnography</td>
<td>Somology and the problem of the body</td>
</tr>
<tr>
<td>1992</td>
<td>Street</td>
<td>Critical ethnography</td>
<td>Clinical nursing practice</td>
</tr>
<tr>
<td>1994</td>
<td>Glass</td>
<td>Critical feminist Mixed method, triangulation</td>
<td>Post registration RNs personal and professional experiences of university nursing education</td>
</tr>
<tr>
<td>1994</td>
<td>Johnstone</td>
<td>Critical feminism</td>
<td>Nursing and the injustices of the law</td>
</tr>
<tr>
<td>1997-2004</td>
<td>Glass</td>
<td>Postmodern feminist ethnography</td>
<td>Professional development experiences of nurse and midwifery academics</td>
</tr>
<tr>
<td>1998</td>
<td>Davis</td>
<td>Feminist postmodern ethnography</td>
<td>Community nursing practice</td>
</tr>
<tr>
<td>2000b-2002</td>
<td>Chiarella</td>
<td>Australian Case Law</td>
<td>The Status of the Registered Nurse in Law, Society &amp; Scholarship</td>
</tr>
<tr>
<td>2001</td>
<td>Lewis</td>
<td>Grounded Theory- Sensemaking paradigm</td>
<td>The clinician manager in rural Western Australia</td>
</tr>
<tr>
<td>2004</td>
<td>Ogle</td>
<td>Critical feminist postmodern ethnography</td>
<td>Managing nurses &amp; being managed by nurses</td>
</tr>
<tr>
<td>2005-2007</td>
<td>Glass</td>
<td>Postmodern feminist ethnography</td>
<td>Nurse and midwifery academics and clinicians experiences of hope, resilience and optimism</td>
</tr>
<tr>
<td>2006</td>
<td>Paliadelis</td>
<td>Feminist</td>
<td>The working world of nursing unit managers.</td>
</tr>
<tr>
<td>2006</td>
<td>Orrock &amp; Lawler</td>
<td>Symbolic Interactionism</td>
<td>Marginalisation of Senior Nurse Managers</td>
</tr>
</tbody>
</table>

Of the selected research studies, noted in this section, grounded theory was applied in three of the relevant research projects: Irurita (1990), Lawler (1991) and Lewis (2001). Critical ethnography informed Street’s (1992) research.
Orrock and Lawler’s (2006) research was informed by symbolic interactionism. Glass applied critical feminism to two of her research studies (Glass 1994; 1998-2000) and in later research projects she applied feminist postmodern ethnography (Glass 1997-2004; 2005). Other researchers who applied feminist postmodern ethnography to their research included Davis (1998), Walter (2003), and Ogle (2004). Critical feminism was applied by Paliadelis (2006). Johnstone (1994) and Chiarella’s (2002, 2000b) Australian Case Law research incorporated a feminist analytic focus.

Not all of these research projects are critiqued in this section. However, the qualitative research methodologies applied by these researchers also raised my awareness of the value these made toward nursing’s knowledge contribution. In this section I have critiqued the research conducted by Paliadelis (2006), Ogle (2004), and Glass (1997-2004; 2005-2007) principally because their research was in a similar area of interest to mine as was their methodological approach. Johnstone (1994), Chiarella (2002, 2000b) and Street’s (1992) seminal works are critiqued in section two of this chapter. Glass and Walter’s (2000) research has been critiqued in section three. In section four of this chapter I incorporated a critique of Irurita (1990) and Lewis’ (2001) research. The other selected studies, Lawler (1991) and Davis (1998), in addition to the projects critiqued in this chapter, informed components of the methodology for my ethnography and are referenced in different parts of chapter four. Orrock and Lawler’s (2006) research was incorporated in chapter two as part of the cultural context potentially influencing the MLWNs’ practice.

Paliadelis’ (2006) feminist qualitative research focused on first-line nurse manager participants (nursing unit managers). She sought to understand the construct of oppressive power in relation to the scope and authority of their role. Her cohort consisted of twenty nurse unit managers employed in public hospitals in NSW. The research design included participant observation and interviews and was informed by Kanter’s (1977) theory of organisational power. Paliadelis’ (2006) results were enlightening but not surprising. There was a strong relationship between participants’ low image of their role and low perceived power. Of relevance was her finding that tensions were evident between the nurses’ strong nursing identity and the organisation’s managerial
expectations of them. The integrated duality of their role plus their lack of preparation and support for managerial duties resulted in the nurse participants feeling undervalued and unsatisfied with work (Paliadelis 2006).

In keeping with her modernist theoretical perspective Paliadelis (2006:heading 7.1) noted that she rejected the participants’ experiences as ‘reflective only of women’s stories’. She claimed that nurses of both gender lacked power and voice within the patriarchal hospital system. Research of this kind was to be applauded because it revealed valuable insights about difficulties experienced by Australian middle-level nurse managers. Paliadelis’ (2006) recommendations centred upon external-to-the-profession improvements. These included organisational policies, revitalised job descriptions and management education that would enhance the nurse unit managers’ perceptions and experience of the role. However, what seemed to be poorly acknowledged was the plethora of research which showed nursing, irrespective of nurses’ gender, as a subjugated occupation and profession. Paliadelis’ (2006) seemed to negate women nurses’ legitimacy of knowledge production. In addition, the study lacked optimism for this level of nurse. Sociopolitical action by nurses was not a proposed option to resolve the problem, rather a paternalistic approach was recommended.

In a different vein to Paliadelis’ (2006) research my interest centred upon understanding what women nurses in middle-level positions experienced as empowering and transformative, disempowering and oppressive. In addition, my interest included how these experiences, viewed within the perspective of an oppression narrative, influenced them to self-manage the multiplicities of their role. My interest was also to give value to their implicit knowledge as legitimate sites for women’s production of knowledge. Further, my research interest was not focused toward specifically identifying external sources to resolve oppressive issues, if these existed.

Ogle’s (2004) doctoral feminist postmodernism ethnography with critical care nurses, of both genders, was undertaken within a metropolitan public hospital in the State of Victoria, Australia. She sought to understand and foreground participants’ voices. Her research focus aimed to understand their embodied experiences of what it meant for nurses to be managed by nurses. Further, she
sought to understand nurse managers’ experiences of being a manager. Her study was highly relevant as my interest in methodology and method was similar. In the present study the focus was on understanding the embodied experiences of nurses in middle-level positions (management and specialist positions) across a horizontal plane. On the other hand, Ogle’s study was from the vertical perspective. Her cohort was eleven nurses in varying hierarchical levels and focused on the participants’ human relationships experiences. In applying a mixed mode of feminist and Foucauldian data analysis, Ogle revealed nine subjectivity positions (2004:192 emphasis in original) within which participants moved between and/or were simultaneously positioned: ‘junior novice – playing second fiddle; detached unemotive 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; and strategist – simply irresistible’.

Ogle (2004) was emphatic about the potential for alternate interpretations to her data analysis, in keeping with postmodernism. Her data revealed that nurse management practices negatively impacted upon nurses’ self-esteem and confidence (Ogle 2004). She also identified that participants were negatively influenced in their practice by dominant positivist and patriarchal discourses, such as managerialism. Of these discourses Ogle (2004:281) revealed them to ‘reinscribe the institutional subordination of women’ by silencing and constraining nurses.

More disturbingly, Ogle (2004) revealed that the nurses reinscribed themselves into positions of subordination. This insight could be likened to Fay’s (1987) quotation of Freire (1970) regarding oppression. Freire’s (in Fay 1987:106) oppression notion referred to those who have unwittingly adapted to living with subjugation and ‘become resigned to it’. However, Ogle (2004) did not proffer that her research participants took Freire’s (1970) critical social science notions to the next level where they also internalised oppressor values and sought to be like their oppressors.
My ethnographic interest aimed to take further the notions of potential competing discourses, such as that revealed by Ogle (2004). I was curious to understand how middle-level women nurses’ self-managed in these potentially opposing dominating culturally constructed discourses. Unlike Freire’s (1970) stance, my assumption was that not all nurses were equally oppressed, nor were they all inscribed by oppressor values. Similar to Ogle (2004), my interest was to apply critical feminism and Foucauldian postmodernist lens to data analysis. However, I was interested to go beyond that level of analysis to incorporate a trifocal analytic process. This depth of analysis, I believed, may reveal additional levels of understanding than that by Ogle (2004) and Paliadelis’ (2006) research and, thus, contribute to the knowledge base relating to nurses in middle-level public hospital positions.

On a more optimistic note was Glass’ (1997-2004; 2005-2007) array of nursing research informed by feminist postmodernism. Her research with women nurse academics incorporated the revealing of practical self-managing strategies; notions which were particularly integral to my research interest. Her results demonstrated destructive competitive workplaces in health care and academic institutions. However, resilience, hope and optimism emerged as subjugated discourses in her multi-sited international ethnography (Glass 1997-2004) and this was the major motivation for the extension to the research, the second project being undertaken from 2005-2007. What Glass (2007:126) found with her cohort of 53 participants, inclusive of 25 Australian nurse academics, was that in their efforts to adjust to the constancy of change they experienced ‘vulnerability, stress and burnout, necessitating active healing interventions and strategies’. Glass (2007) revealed that the nurse academics practised positive survival strategies and they found importance in ‘their resilience, autonomy, self reliance and confidence to interface their workplace’ and, to retain personal emotional wellbeing (Glass 2007:126). Glass’ participants moved through their vulnerable state of being, viewed as a weakness, to an empowered position where they inverted the negatively constructed vulnerability (Glass & Davis 2004). The importance of Glass’ (1997-2004;2005-2007) and Ogle’s (2004) research was that the feminist ethic to foreground participant’s individual and multiple voices was retained within an emancipatory political intent. Glass (2007) took her analysis to a new level whereby the participants gave voice to
positive and optimistic ways of being. Minimal literature was found that centred optimism within nursing research.

**Summary of Section 1**
The purpose of the first section of this chapter was to bring attention to some Australian nursing related postpositivist research which contributed to the body of nursing knowledge in areas of similar interest to my research objectives, methodology and analytic focus. The three research projects critiqued in this section applied critical feminist and/or feminist postmodernism as methodologies that revealed important insights. These Australian research projects indicated an opportunity for further research related to middle-level nurses’ experience of working in Australian public hospitals. Insights, which foregrounded women nurses’ voices, from such a study may also inform the practices of other similar women nurses at an international level.

Critiqued in the next section are several different but related discourses. These discourses revealed the difficulties the nursing profession experienced in having its status and distinctive knowledge recognised as having parity with more dominant patriarchal discourses.

**Section 2. The Struggling Status of Nursing**

**Introduction to this section**
The following five subsections include critical discussion related to research and literature focused upon the subjugation of nursing knowledge. The studies critiqued in this section highlighted nurses’ difficulty in breaching the hegemonic patriarchal discourses of medicine and law. In the final subsection the recently legislated role of the Nurse Practitioner in Australia is discussed. My critique was within the context of the legitimation of clinical nursing expertise. However, literature was also shown that subjected this advancement by nurses’ critical and concerned potential shift of nursing practice toward medical practice.

In the subsection below pertinent research and literature is critiqued that located nursing knowledge as subjugated.
Subjugation of Nursing Knowledge

The literature and research critiqued in this sub-section are listed in Table 9. ‘Literature and Research related to Subjugation of Nursing Knowledge’.

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<thead>
<tr>
<th>Year</th>
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<tbody>
<tr>
<td>2007</td>
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<tr>
<td>2007</td>
<td>Glass</td>
</tr>
<tr>
<td>2007</td>
<td>Reimer Kirkham, Baumbusch, Schultz &amp; Anderson</td>
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<tr>
<td>2006</td>
<td>Holmes, Murray, Perron &amp; Rail</td>
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<td>2006</td>
<td>Kagan</td>
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<td>2006</td>
<td>Paley</td>
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<td>2005</td>
<td>Rolfe</td>
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<td>2002</td>
<td>Holmes &amp; Gastaldo</td>
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<tr>
<td>2002</td>
<td>Winch, Creedy &amp; Chaboyer</td>
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<td>2001</td>
<td>Ceci &amp; McIntyre</td>
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<tr>
<td>2000b/2002</td>
<td>Chiarella</td>
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<tr>
<td>2001b</td>
<td>Manias &amp; Street</td>
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<td>2000</td>
<td>Glass</td>
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<td>1999</td>
<td>Hamer &amp; Collinson</td>
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<td>1999</td>
<td>Traynor</td>
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<td>1994</td>
<td>Johnstone</td>
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<tr>
<td>1992</td>
<td>Street</td>
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<td>1987</td>
<td>MacKinnon</td>
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The seminal work by Megan-Jane Johnstone (1994) in her text, *Nursing and the injustices of the law*, signified Australian nurses’ long-standing patriarchal resistance by the law to legitimate the autonomy of the nursing profession. Her feminist critique of the subjugation of nurses was through exposure of case law exemplars from Australia, United Kingdom and United States. More recently, and as daunting, was Mary Chiarella’s (2002) seminal work, *The Legal Professional Status of Nursing*. Her text was based upon her Australian doctoral thesis (2000b). Different to Johnstone’s (1994) focus, Chiarella demonstrated the complex and often confusing role and identity of Australian nurses as revealed by her analysis of Australian case law. The perceptions she revealed were held both by nurses themselves and the more dominant identities such as those in the medical and legal professions, and health institutional administrators. Her work, like that of Johnstone (1994), also highlighted the historical marginalisation of nurses within the dominant socially constructed case law and medicine in Australia (Chiarella 2002). The images of the nursing profession identified by Chiarella (2002) exposed many taken-for-granted understandings of why nurses’ world-view of themselves and of their profession

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is as it is. The specific images that emerged from her case law analysis included three dominant ‘insider’ stock stories (Chiarella 2002:30) of domestic worker, doctor’s handmaiden, and subordinate professional. The ‘outsider’ stories (Chiarella 2002:31) included ministering angel and autonomous professional, and were those which nurses actively promoted through their own writings and endeavours. The deficiency of political and legal empowerment as a feature of nursing, in Chiarella’s (2000a) work, further highlighted the persistence of the marginalisation of nurses’ voice and knowledge.

Chiarella’s (2002) and Johnstone’s (1994) works were important to my research interest as there was no particular grouped reference made to nurses in middle-level positions. My research interest was not focused toward investigating legal experiences from the middle-level women nurses. However, I was interested to reveal realist exemplars of their lived experience that related to subjugation, empowerment and/or transformation. Further, I was interested to provide a public forum that promoted legitimisation of their knowledge production practices within the context of discourses that constructed their working culture.

Manias and Street’s (2001b:132) Australian critical ethnography explored how critical care nurses and doctors constructed their practices through knowledge to inform their decision making. From a postmodern Foucauldian analysis, they revealed that nurses and doctors’ knowledge was discursively constituted (Manias & Street 2001b). Sometimes nurses’ knowledge was subjugated and at other times it was acknowledged and influenced by the social construction of the specific context (Manias & Street 2001b). The research was a valuable reference point for the possibility to take further Manias and Street’s (2001b) insights. My interest was to reveal more than participants subjectivity positions within their cultural discourses. By integrating critical feminist and Foucauldian analytic perspectives to ethnographic data my interest was to understand resistive and/or productive self-managing practices.

Almost fifteen years earlier, of relevance to my research interest, was Street’s (1992) seminal critical ethnography informed by feminism and postmodernism. Her research focused upon Australian hospital based clinical nursing practice with four nurse participants. My research interest was to understand nurses’
experience of practicing within middle-level hospital roles. Street’s (Giroux & McLaren in Street 1992:introduction 1) ethnographic analysis was structured around understanding how nurses ‘critique and contest medical domination, administrative structures, gender politics, and the hierarchies of power and privilege that devalue their clinical knowledge and practice’. Her emergent ‘nurture/knowledge’ theory (Giroux & McLaren in Street 1992:introduction 2) was both a critique and an extension of Foucault’s power/knowledge concepts. She revealed that the nurses struggled against the hegemonic discourses of the medical establishment. However, Street (1992) had not revealed realist exemplar resistive practices by the nurses to the domination, nor were empowering nurse practices identified. In a similar perspective, Ceci and McIntyre (2001) asserted that nurses’ endeavoured to have their knowledge matter. An opportunity was revealed from such research to partially locate part of my research focus: to reveal practical ways nurses either resisted being re-inscribed by patriarchal discourses and/or endeavoured to have their nursing knowledge inscribed as legitimate within patriarchal discourse constructs.

Chiarella (2002), Manias and Street (2001b), Ceci and McIntyre (2001) and Street (1992) clearly articulated that nursing knowledge had no authority or power. The reason for this was that medical knowledge was ‘the’ legitimate, and, therefore, dominant and patriarchal discourse in medicine, as well as in law. These dominant discourses were ‘exercised as social control to reproduce and support the class and gender of [the] doctor’ (Street 1992:8). Such taken-for-granted discourses were disempowering and marginalising to nurses (Chiarella 2002; Glass 2000). Chiarella’s (2000b) research supported MacKinnon’s (1987) assertion that nursing knowledge, as women’s knowledge, had been historically denied by law and exclusive of women’s perspectives. These nurse researchers expressed similar notions to that posed by Kagan (2006) who drew from Ashley’s mid-1970s nursing feminist research. Ashley brought attention to the ‘hierarchical disparities among professionals in the hospital and the lack of respect toward nurses’ (Kagan 2006:318).

From a different nursing knowledge and clinical judgment perspective Paley (2006) was critical of the relatively recent focus upon evidence-based nursing practice. Paley (2006:abstract) viewed the emphasis upon evidence as narrow
rather than an inclusive concept of incorporating ‘patterns of knowing’. Randomised controlled trials were rated the highest credible knowledge criteria used by the Centre for Evidence Based Medicine with qualitative studies low on its scale (Holmes, Murray, Perron, & Rail 2006). Paraphrasing from Barker (2000) Paley (2006:frame 2) drew attention to the risk that if nursing based its practice primarily on positivist ‘generalisable evidence’ its traditional practice could be demolished. In a similar critical context, Reimer, Kirkham, Baumbusch, Schultz and Anderson (2007:frame 7), through their postcolonial feminist lens, argued that evidence based practice movement assumed a ‘standardized patient’ with the ‘possibility of erasure of individual differences’. In rebuttal to this concern was the recent establishment of the Cochrane Qualitative Research Methods Group (2007) which indicated its aim was to develop systematic reviews based upon evidence from qualitative methods. However, the breakthrough to align parity of legitimacy of qualitative knowledge with that of the historically embedded preference for positivist evidence is yet to be shown. This issue was highlighted by Glass (2007). She drew attention to the international dilemma for women nurse academics, especially within Australian universities, of the disparity of their research, often qualitative, being benchmarked against the major scientific disciplines. She argued that the majority of nursing research focused upon practice-based research or that related to their professional stance. The need for peer assessment of such research was argued (Glass 2007). My research interest was to add value to the body of qualitative knowledge inclusive of expected research audit and validity analytic trails.

The rise of scientific evidence-based nursing practice paralleled that of the medically dominated view of a hierarchy of legitimate knowledge (Joanna Briggs Institute for Evidence Based Nursing and Midwifery 2007). This focus was a response to the ongoing need for nurses to demonstrate their practice was scientifically based as a means to enhance the general public’s opinion of nurses and to respond to threats of managerial control (Traynor 1999). The benefit for fostering research and its ability to credentialise clinical nursing practice cannot be disputed. Important applications for nursing practice have resulted of the works emanating from the Centre for Evidence Based Medicine, its nursing derivatives of the UK Cochrane Centre (Holmes, Murray, Perron, &
Rail 2006) and its world-wide organisations such as Australia’s Joanna Briggs Institute for Evidence Based Nursing (Hamer & Collinson 1999). But, of non-positivist knowledge, I fully agreed with Winch, Creedy and Chaboyer (2002:frame 6) when they encouraged nurses to ensure that ‘truth taxonomies capture, celebrate and preserve the intuitive experience of nursing’. Similar urgings were made by Rolfe (2005) who emphasised the value of reflection on practice as relevant nursing knowledge. In other words, nursing knowledge was also produced through research that emerged out of reflective practice as well as from theory generated from positivist methodologies. Ethnographic research method, my method of interest, was located within the realm of reflective practice.

On a positive note, Holmes and Gastaldo (2002) used Foucauldian critique of nursing and governmentality. These authors inverted the subjugation of nursing to reconceptualise it as an ‘internationally recognized profession of fundamental importance to the provision of healing and care in the Western world’ (Holmes & Gastaldo 2002:frame 2). They celebrated the advances in nursing and nurses’ endeavours of political influence. Without minimising the extent of nursing’s subjugation and non-privileged status these authors focused upon nurses’ constructive aspects of power. They viewed nurses’ use of power as a means to reframe the taken-for-granted unified oppressive state most often reflected in the literature (Holmes & Gastaldo 2002). I found this work refreshing and inspiring. This study was among the few that embraced the breadth of Foucault’s concepts of resistive and productive power possibilities within the construct of nursing at an individual and collective level. Further, it gave hope to the future for nursing within a context of acknowledging the problems confronting nursing. Holmes and Gastald’s (2002) application of a Foucauldian critique to qualitative data was important to demonstrate, as with previously critiqued Foucauldian analysed research, its suitability to reveal valuable insights. This supported a gap in knowledge within which to locate my research interest.

Literature that focused upon positive directions toward legitimating expert clinical nursing knowledge is critiqued in a later sub-section under the heading Nurse Practitioner – The Validation of Clinical Nursing Expertise.
In the next sub-section I critique several research publications in which the value of care, as a value attributed to nursing, was found to be marginalised and subjugated.

**Nursing ‘Care’ as Subjugated Knowledge**

The literature and research critiqued in this sub-section are listed in Table 10. Literature and Research related to ‘Nursing Care as Subjugated Knowledge’.

Table 10. Literature and Research related to Nursing Care as Subjugated Knowledge

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<thead>
<tr>
<th>Year</th>
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<tbody>
<tr>
<td>2007</td>
<td>Glass</td>
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<tr>
<td>2004</td>
<td>Freshwater &amp; Stickley</td>
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<tr>
<td>2004</td>
<td>Peter, Lunardi &amp; Macfarlane</td>
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<td>2002</td>
<td>Cloyes</td>
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<td>2001</td>
<td>Paley</td>
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<tr>
<td>1996</td>
<td>Falk Rafael</td>
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<td>1996</td>
<td>Goleman</td>
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As an extension of the subjugation of nursing knowledge in general, I found three studies that applied feminist and postmodern methodologies which demonstrated the notion that caring was a marginalised value. The notion of caring was not a specific focus of my research interest but rather an assumed value held by nurses. The publications critiqued in this sub section evoked a sense of unease that caring by nurses was subjugated to medicine and had been devalued within the corporate agenda. The literature, as critiqued below, indicated a need for further critical interrogation of non-nursing discourses. In particular there was a need to further critique the discourses of medicine and managerialism that may have encroached on nursing discourse. The aim of the critique was to additionally uncover the impact of non-nursing discourses and elucidate nurses’ resistive practices.

Paley (2001), as an example, applied a Foucauldian critique to his extensive nursing literature review. He asserted that the ways of knowing what constituted caring as a value and practice was an elusive notion and hundreds of years out of date. However, from my postmodern perspective, the elusiveness of the concept of caring was an optimist and positive one. To look to essentialise core elements of that value might subjugate or marginalise other attributes, and its
fluidity of meaning, which may be of equal importance but not legitimated as important.

In contrast to Paley’s assertions, Freshwater and Stickley (2004) aligned the concept of nursing caring with emotional intelligence. Glass (2007) aligned the value of emotional intelligence to successful human relationships and management, drawing the connection to workplace culture for nurse academics. Goleman (1996:43), an early proponent of emotional intelligence, aligned it with five characteristics: ‘knowing one’s emotions; managing emotions; motivating oneself; recognizing emotion in others; and handling relationships’. From these perspectives it could be viewed that caring was a component notion in successful inter-personal relationships. My research interest incorporated gaining understanding of MLWNS’ experience related to their work relationships.

Freshwater and Stickley (2004) proposed that as a transformational learning process emotional intelligence should be integrated into nursing education curricula, practice and research. Their assertion related to the risk that the notion of care, ‘the very act upon which the profession is established’ (Freshwater & Stickley 2004:frame 5), would be marginalised in the health legislator’s pursuit of efficiency of productivity. In other words, the value of care embedded as a principal feature of nursing would be economically dismissed. The potential impact of such action indicated the demise of nursing and its replacement by a more fiscally controlled practice role, but not that of nurses. In respect to this scholarly work my research interest was to reveal, at the practice nursing level, whether the nursing care value was at risk of being subsumed by more dominant discourses, such as managerialism.

From a different perspective, Falk Rafael (1996) applied a feminist Foucauldian critique to the concept of care in relation to power. She historicised the subjugation of the medically dominated construction of nursing’s knowledge. Inherent within this subjugation was the value of caring, and its male gendered links with feminine characteristics. Falk Rafael (1996) noted the invisibility of caring as nursing knowledge and skill. This invisibility was pointedly demonstrated in the exclusion of nurses’ caring, as a commodity, from hospital
bills, and the replacement of registered nurses with unlicensed and unskilled personnel. The economic invisibility related to nursing care, as a practice, is more specifically critiqued later in this chapter.

Falk Rafael’s (1996) dialectic multi-layered analysis was theoretically informed by Hegel. She identified three layers in the relationship between caring and power: ‘ordered caring; assimilated caring; and empowered caring’ (Falk Rafael 1996:frame 1). Ordered caring related to the deference of nurses to fulfil medical orders and Nightingale’s original notion that women naturally care. Assimilated caring reflected resistance to the dominant discourse concerning power and caring. Empowered caring was linked with a radical feminist perspective of the personal being political. Empowered caring incorporated the principles of gender/knowledge equality intertwined with productive power. This form of nursing caring sought to breach the patriarchal discourse to have the voices of nursing heard. In a more recent scholarly paper Cloyes (2002) extensively argued for developing a feminist political theory of care as one way of politicising both care and nursing. Prior to critiquing Falk Rafael (1996) and Cloyes' (2002) work, I briefly describe another research, below, which also related to care as a nursing value.

From a nursing empirical research literature review, applying a Foucauldian feminist methodology, Peter, Lunardi and Macfarlane (2004) identified that nurses resisted when experiencing moral conflict by the actions of health professionals. However, they also cited instances where the nurse had not resisted, perhaps as a ‘result of internalised oppression’ (Peter, Lunardi & Macfarlane 2004:frame 4). Examples of the nurses’ resistance included: speaking up and confrontation, reporting to higher authority or whistleblowing, educating patients and families to take action, refusing to participate in care, and other actions such as ‘responsible subversion’ (Peter, Lunardi & Macfarlane 2004:frame 4). They proposed a number of individually-based politically intentioned strategies that aimed to increase nurses’ resistance to ethically compromising situations, inclusive of ethics education with a feminist empowerment focus (Peter, Lunardi & Macfarlane 2004).
The notions of care as a nursing value and its linking to being elusive (Paley 2001), emotional intelligence and economic invisibility (Freshwater & Stickley 2004), femininity and power politics (Falk Rafael 1996) and a need for a feminist informed nursing ethics education (Peter, Lunardi & Macfarlane 2004) were important insights. What these research and scholarly works indicated was also a research space within which to investigate women nurses’ experiences whose roles amalgamated corporate and professional agendas, like that of middle-level nurses practising in public hospitals. Nurses within senior health organisational positions could be assumed to be in a confluence of different values, such as economics and care. Further research, like my research interest, could reveal nurse’s voices and their points of power/knowledge resistance and productivity as self-managing strategies. Inherent in such an investigation would be a critique of various taken-for-granted values as constructed within discourses present in day-to-day practice.

In the next sub-section literature is critiqued that further demonstrated nursing knowledge, in this case that of nurse managers, which was unacknowledged as expert.

**Unacknowledged Expertise of the Nurse Manager**

The literature and research critiqued in this sub-section are listed in Table 11. Literature and Research related to ‘Unacknowledged Expertise of the Nurse Manager’.

Table 11. Literature and Research related to Unacknowledged Expertise of the Nurse Manager.

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<tr>
<td>2001</td>
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<td>1999</td>
<td>Malloch</td>
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<td>1999</td>
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<td>1994</td>
<td>Chase</td>
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What became apparent from my literature review was that the status of nurses in management positions was in urgent need of being formally validated as expert. The nature of educational preparation of middle-level nurses was not an integral aspect of my research interest but as a discourse surrounding this focus it was important to review and critique.
Chase (1994) identified that American nurses in management positions needed to be competent in a wide range of skills to achieve their diverse scope of responsibilities. A similar call for a focus on nursing management education was made at the 1999 inaugural National Conference for Nurses in Management Conference in Perth, WA, by Professor Anne McMurray (1999) and Dr. Kathy Malloch (1999). McMurray (1999) focused on the Australian situation, whereas Malloch (1999) spoke from the American perspective. Both scholars identified the urgent need for internal-to-the-profession nursing management courses that incorporated nursing values and ‘the interdependence of key roles in the health system’ (McMurray 1999:frame 2). McMurray’s concern, like that of Duffield and Franks’ (2001:89) concern for nurse managers, related to the risk of the survival of the Australian nursing profession if it did not enhance self-regulation and external credibility through improved education and practice strategies. Such challenges continued to be relevant in 2007.

At a local WA State level the crisis of lack of professional profile and recognition of nurses’ expertise in management roles was formally addressed. In 2003 the OCNO, DoHWA, through its annual sponsorship ‘Vital Link’ initiative offered WA nurses the opportunity to complete postgraduate nursing leadership courses (DoHWA 2005).

The absence of voices of nurses’ expertise in management positions was further reviewed. Below, I discuss this notion in more detail within the context of management teaching textbooks which also indicated a site for locating my research interest.

**Nurse Managers’ Voices - Silenced in Educational Publications**

The literature and research critiqued in this sub-section are listed in Table 12. Literature and Research related to ‘Nurse Managers’ Voices – Silenced in Education Publications’.

The lack of inclusion in management teaching textbooks of reality-based narratives further demonstrated that nurses in management positions have no authorial legitimated voice. A plethora of literature was reviewed that told nurses in management roles how the job should be done. No publications were
found that celebrated the local and embodied expert knowledge of these nurses. In my management teaching programs I particularly drew from management theories dating from the 1940s through to contemporary and innovative management and leadership theories. Such material would continue to be integral reference sources for my teaching purposes. However, the absence of nurses’ voices in such material, as highlighted by the following critique, provided a specific gap in knowledge within which my proposed ethnography could be located.

Table 12. Literature and Research related to Nurse Managers’ Voices – Silenced in Education Publications.

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<td>Sullivan &amp; Decker</td>
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There was a plethora of written material and educational programs available to support clinicians’ transition into management roles. This written material formed part of reference lists for nursing education programs in which I had taught (Courtney, Nash, & Thornton 2004; Marquis & Huston 2003, 2006; Porter-O’Grady 1992; Quinn, Faerman, Thompson, & McGrath 1996; Senge, Kleiner, Roberts, Ross, & Smith 1994; Sullivan & Decker 1997; Swansburg 1996; Yoder-Wise 1999). The texts, for example, focused on ‘how to’ become an effective leader and/or manager, they were skill development focused and contextualised around contemporary commercial business based theories that had historically evolved since the early 1940s.

Fletcher (1999) noted that such texts focused upon theories which were male biased and exclusive of women’s voices. Further, Huntington and Gilmour’s (2001) extensive nursing literature review, informed by Foucault’s
postmodernism and feminism, identified that medical knowledge continued to be the dominant discourse related to nursing texts. They recommended nursing texts needed to be rewritten to reflect ‘the reality of nurses’ work’ (Huntington & Gilmour 2001:abstract). Barker and Young (1994:25) proffered a feminist perspective stating that nursing leaders ‘need to recognize and value their unique ways of being, knowing, and leading’.

One text by Lawson, Rotem and Bates (1996) *From Clinician to Manager* was an Australian focused book. This was one of the rare texts that included the occasional reality comments from clinicians who had made the step-change into managerial positions. Like other nursing management texts, for example Daly, Speedy and Jackson (2004), Marquis and Huston (2006), Lawson, Rotem and Bates’ (1996:95) excluded transformative strategies used by individual nurses to breach hegemonic patriarchal leadership/management dominance. Nor was it evident how nurses inscribed nursing values and knowledge as a mutually valuable taken-for-granted discourse of health care practices. The gap in knowledge in these texts was the absence of voices from women nurse leaders and managers at the coal face. This gap in knowledge further affirmed the location for an ethnography that sought to foreground nurses’ voices of the ways they had learned to practically function as managers and leaders.

The lack of acknowledged expertise of nurses in middle-level management roles contrasted markedly from that for nurses who were in middle-level clinical specialist roles. It is this aspect that I now critique in the next sub-section below.

**Nurse Practitioner – The Validation of Clinical Nursing Expertise**

The literature and research critiqued in this sub-section are listed in Table 13. Literature and Research related to ‘Nurse Practitioner – The Validation of Clinical Nursing Expertise’.
Table 13. Literature and Research related to Nurse Practitioner – The Validation of Clinical Nursing Expertise.

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<thead>
<tr>
<th>Year</th>
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<td>Chiarella</td>
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<td>2006</td>
<td>NSW Health</td>
</tr>
<tr>
<td>2005</td>
<td>Elsom, Happell &amp; Manias</td>
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<tr>
<td>2005</td>
<td>Fisher</td>
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<td>2005</td>
<td>NBWA</td>
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<td>2005</td>
<td>Rashotte</td>
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<td>2004</td>
<td>Adams &amp; Begley</td>
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<tr>
<td>2004</td>
<td>Bagg</td>
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<tr>
<td>2004a, b, c, d</td>
<td>Della</td>
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<td>2004</td>
<td>Green</td>
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<tr>
<td>2004</td>
<td>Northrup, Tschanz, Olynk, Makaroff, Szabo &amp; Biasio</td>
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<td>2004</td>
<td>Reel</td>
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<tr>
<td>2000</td>
<td>Offredy</td>
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In the past twenty five years in Australia three significant nursing professional breakthroughs provided an impetus for viewing optimistically the future for clinical nursing practice. These breakthroughs related to the transfer of nursing training from the traditional hospital-based to university education, advances in the education status for nurses practicing in the clinical setting and their scope of nursing practice. The impact from these changes also positively reverberated to incorporate improved status for nurse educators, academics and researchers within the university and health care systems. As newly emergent advances these are presented below, but not critiqued, in this sub-section because of their sociopolitical influence upon the Australian and WA nursing profession.

In 1984 I was employed as a nurse educator in a hospital-based diploma of nursing course, Fremantle Hospital, WA, when the Australian federal government legislated that the minimum entry-to-practice qualification for a registered nurse was to be at university diploma. The hospital based diploma training was to be phased out across Australia over a three year period. Curtin University of Technology, WA, was among the very early adopters, in 1974, to offer degree qualification for nurses. I was privileged to experience being the last nurse educator in Fremantle Hospital to celebrate the graduation of its final group of student nurses. I was also excited by the anticipated enhanced professional nursing identity and the increased valuing of nursing knowledge by it being situated within the university setting. The Australian nursing profession was among the few worldwide that had achieved such a major and significant
legislative breakthrough. It was also an important declaration of the value nursing practice contributed toward the high standard of health care in Australia.

Since the 1990s there have been dedicated nursing professionals across Australia who undertook a highly resistive pursuit against the medical and legal fraternity to gain another outstanding success for nurses – legislation for the advanced role of the nurse practitioner (Adams & Begley 2004; Chiarella 1998; Della 2004a, b, c, d; Reel 2004). Offredy (2000) affirmed that at the 1990 NSW Nurses' Association Annual Conference the then Minister for Health articulated support for independent nursing practice. In 1998, NSW was the first Australian State to protect by legislation the title nurse practitioner with changes occurring to The Nurses Act (1991), The Poisons and Therapeutic Goods Act (1996), and The Pharmacy Act (1964) (Offredy 2000). Since 1998 other Australian States also gained legislative authority related to Nurse Practitioner, a registered nurse whose scope of practice was at higher degree qualification and with specifically authorised designated clinical level role (Bagg 2004, Della 2004a, b, c, d). The publication of *The Nurse Practitioner Series* by the OCNO, DoHWA, in 2004 was a celebration to the emergence of the Nurse Practitioner role and demonstrated the legitimation of clinical nursing expert knowledge.

From an alternate perspective, concerned nursing scholars drew attention to the risks associated with potentially diluting the expertise of nursing by shifting the boundaries of practice into some areas of traditional medical practice. Green's (2004:abstract) survey, used the ‘Caring Behaviors Inventory’ with nurse practitioners (*n* = 348) in an American State. Green's (2004) concern related to the potential reduction in nurses' valuing caring behaviours over that of productivity by sacrificing primary care nursing practices. Of similar concern to that of Green (2004) Elsom, Happell and Manias (2005) cautioned the Australian nursing profession to be cognisant of the risk of becoming a less costly substitute if nursing practice encroached into the field of medical practice. Elsom, Happell and Manias’ (2005) concern, a result of their international research review, referred to the expanded role of Nurse Practitioners in Victoria, Australia as that of practice previously within the domain of medicine. Their critique concluded that, ‘being at the apex of nursing practice, means that the
more a nurse is like a doctor, the better or more advanced nurse he or she becomes’ (Elsom, Happell & Manias 2005:frame 1).

Offredy’s (2000) research provided rich personal perspectives of Australian nurse practitioner participants’ lived experience which contrasted with Rashotte’s (2005) concern. Green (2004) had a similar perspective to Rashotte’s (2005:frame 2) assertion that the discourses dominating the nurse practitioner literature was principally ‘instrumental and economic’. Further, Rashotte (2005) raised the danger for nurses if these discourses became the dominant ways of nursing knowing.

In an English ethnography with eight district nurse practitioners, Fisher (2005) noted that the initial intentions for nurses’ prescribing medications aimed to improve patient care and improve the status of the nursing profession. However, although his research was still in the preliminary stages, it appeared that for some nurse practitioners they were reverting to, or continuing pre-prescribing behaviour with deference to the general practitioner and the reinforcing of hierarchical norms (Fisher 2005).

The changed terrain for Australian nurses to be able to progress into the legitimated expert Nurse Practitioner roles indicated the possibility for enhanced optimism for the future of nursing practice. The emergent expanded scope of practice for Australian nurses was not integral to my research focus. However, the literature indicated the pathway for these nurses was fraught with risks that nursing knowledge may continue to struggle for legitimacy, was noted as a concern among some nursing professionals.

At this time too, as the Nurse Practitioner roles in Australia were emerging there were also positive new directions for localised professional nursing practices to gain ascendancy in recognition of legitimate models of nursing care practice. For example, the introduction of the NBWA Scope of Nursing Practice – Decision Making Model (2005) was discussed in the previous chapter. Further, the First Report on the Models of Care Project (NSW Health 2006), compiled by Professor Mary Chiarella and Dr Cecilia Lau, and highlighted innovative practices by nurses and midwives. This report aimed to advise the Chief
Nursing Officer, NSW, concerning State governmental strategic planning and decisions regarding nursing and midwifery workforce. The report demonstrated that across NSW nurses were using research skills at the practice level; they incorporated both evidence-based patient care knowledge and patient assessment analytic skills to a high standard.

The focus of this sub-section related to the optimistic recent advances in nursing education and clinical expertise within Australia. However, such advances were also shown by my literature review to incorporate inter-nursing concerns that unique nursing knowledge had not yet achieved parity of legitimacy with that of medical knowledge. Of concern was that the advances anticipated of the nurse practitioner legislation may draw nursing practice closer toward that of medical practice, with the potential demise of the uniqueness of nursing knowledge.

**Summary of Section 2**
The literature and research critiqued in this section showed a persistent struggle for nursing to resist being a subordinated profession, discipline or occupation. The difficulty for the nursing profession to independently ‘advance as a scholarly academic discipline and practice profession’ was scholastically explored by a group of concerned Canadian nurses, Northrup, Tschanz, Olynyk, Makaroff, Szabo, and Biasio (2004:abstract). Their ensuing discussion complimented the literature and research I reviewed. They showed that the place of nursing knowledge and status continued to be subjugated. Inherent in the following quotation from Northrup et al, was the possibility for the inclusion of my research interest to contribute to the body of nursing knowledge:

> If nursing is to find full expression within mainstream healthcare, nurses must set the stage for a full exploration of their difference, their defining qualities, their unique talents, their distinct purposes, and their revolutionary spirit. (2004:60 emphasis added)

I acknowledged the risks and criticisms directed toward the role of nurse practitioner. However, it seemed that the nursing profession globally had the potential to instill much needed optimism and motivation for nurses who chose
to take up specialty clinical roles. This notion was supported by the optimistic report on innovative models of nursing and midwifery practice undertaken by Chiarella and Lau (NSW Health 2006). In contrast to the optimistic perspectives for nursing practice expertise the literature showed a lack of recognition of the status of nursing management expertise.

My research interest did not include nurses who specifically held nurse practitioner roles. I was interested to include participants who were identified as clinical experts and nurses who held middle-level management roles. Hence, the above literature was important and partially affirmed the suitability for my research.

In the next section literature and research are critiqued that focused upon two divergent discourses related to healthy nursing workplace culture and destructive inter-nurse relationships. The cultural context and inter-personal relationships related to the experiences for middle-level women nurses were of particular interest to my research focus. My research interest included the potential revealing of nurses’ self-managing strategies that empowered and/or disempowered them to be in a healthy culture and to resist oppression. The diversity of the discourses critiqued in the next section also provided confidence to locate my research interest.

Section 3. Inter-Nursing Conflicting Cultural Tensions

Introduction to this section

The research critiqued in the following three sub-sections demonstrates marked similarities between the need for nurses to be provided healthier workplaces. It also shows overwhelming research evidence of the destructive environment within which many nurses work. Something was seriously missing from the literature I reviewed. It was evident that insufficient numbers of nursing leaders in health care organisations were taking the initiative to unconditionally ensure nurses’ workplaces were healthy. As I indicate below, the patriarchal oppression narrative was shown to exist in the nursing cultural context. A major part of my research interest was located within the feminist oppressive
narrative. Hence, the following reviewed literature was critical to identify if there was a location within which to situate my research.

Firstly, the following sub-section critiques literature that focused upon the importance for a healthy nursing workplace culture.

**Initiatives to Create Healthy Nursing Workplace Environments**
The literature and research critiqued in this section are listed in Table 14. Literature and Research related to ‘Initiatives to Create Healthy Nursing Workplace Environments’.

Table 14. Literature and Research related to Initiatives to Create Healthy Nursing Workplace Environments.

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<tr>
<td>2007</td>
<td>Jones</td>
</tr>
<tr>
<td>2007</td>
<td>Zivnuska, Ketchen, &amp; Snow</td>
</tr>
<tr>
<td>2006</td>
<td>Carney</td>
</tr>
<tr>
<td>2006b</td>
<td>Maak and Pless</td>
</tr>
<tr>
<td>2005</td>
<td>No author, AACN Standards</td>
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<tr>
<td>2002</td>
<td>Wesorick</td>
</tr>
<tr>
<td>2001</td>
<td>Aiken, Clarke, Sloane, Sochalski, Busse, Clarke, Giovannetti, Hunt, Rafferty, &amp; Shamian</td>
</tr>
<tr>
<td>2001</td>
<td>Clegg</td>
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<td>1997</td>
<td>Roberts</td>
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Concerning the moral imperative for healthy workplaces for nurses, initiatives were recommended to nurse leaders in the American Association of Critical-Care Nurses’ (AACN) ‘Standards for Establishing and Sustaining Healthy Work Environments’ (No author, AACN 2005). These standards made explicit the links between quality related to work environment, nursing practice and patient care outcomes. The standards were ‘evidence-based and relationship-centered principles of professional practice’ (No author, AACN Standards 2005:frame 3). In brief, the standards related to: skilled communication; true collaboration; effective decision making; appropriate staffing; meaningful recognition of nurses; and authentic leadership. The important focus for these standards was upon effective inter-personal relationships among the health professional groups. As previously referenced, Glass (2007) and Freshwater and Stickley (2004) highlighted links between emotional intelligence, successful human
relationships and successful management practices. No research had yet been undertaken to assess the effectiveness of the standards.

In a similar manner to the AACN ‘Standards for Establishing and Sustaining Healthy Work Environments’ (No author, AACN 2005), Maak and Pless (2006b) also argued that responsible leadership encompassed nurturing and caring by and with nurses. Further, it was argued that ‘rationality – even bounded rationality – may be a modern myth’ (Zivnuska, Ketchen, & Snow 2007:70) in contemporary organisations as emotions now play an integral role in workplace attractiveness and retention of staff. I also found it curious that the theme for 2007 International Nurses Day was ‘Positive practice environments: quality workplaces = quality patient care’ (Jones 2007:frame 1). In my view, the explication of healthy culture-setting standards, and an international nursing focus upon healthy nursing practice settings, were an enigma and seemingly contradictory to a profession in which care was an embedded value. Was it that nurse leaders had ceased valuing, nurturing and enacting these values toward nurses that, therefore, required the development of guidelines and the special international dedication to collegiate nursing relationships? This was an opportunity to partially locate my research interest with nurses in middle-level senior nursing positions to understand the nature of the culture within which they practised.

From a different workplace culture viewpoint, an international survey with nurses from the United States, Canada, England, Scotland, and Germany, (Aiken, Clarke, Sloane, Sochalski, Busse, Clarke, Giovannetti, Hunt, Rafferty, & Shamian 2001) highlighted that the shortage of hospital nurses in Western countries would continue to worsen. Banks (2007:7) also pointedly predicted the crisis in the WA skilled labour force, inclusive of the chronic shortage of nurses, would continue through to 2016. The major contributing factors for nursing workforce shortages included work dissatisfaction, nursing aging demographics, low levels of loyalty to the hospital by young qualified nurses (Aiken, Clarke, Sloane, Sochalski, Busse, Clarke, Giovannetti, Hunt, Rafferty, & Shamian 2001). The research respondents’ dissatisfaction related to hospitals’ poor work design and workforce management. In my interpretation, these findings aligned with an unhealthy workplace culture. It also indicated that
relationships between managers and clinician nurses was problematic, not
dissimilar insights as revealed by Ogle (2004), as critiqued in section one of this
chapter.

Wesorick (2002), from a different perspective, recommended that the problems
of nurses’ burnout needed to be viewed alongside those of fiscal constraints
and quality issues. Prevention of nurses’ burnout could be achieved by
sustainable healthy work culture at the direct patient care service level
(Wesorick 2002). It could be argued that there was also an urgent need to more
publicly celebrate nurses’ transformative and liberatory actions that achieved
healthy workplaces. These kinds of strategies, if enacted, may convince nurses
of the positive possibilities of being and staying a nurse. It was these kinds of
empowering transformative strategies that formed a part of my research
interest.

Establishing a culture of shared ethical values and standards were noted as
principal features of transformational leaders (Clegg 2001). It was also asserted
to be about having a vision that incorporated a positive image which engaged
leaders and followers (Clegg 2001), similar to that proposed as a vision for WA
nursing (Pinch & Della 2001). This kind of leadership practice also aimed to
promote a healthy work place and a reduction in occupational stress (Clegg
2001). Of leadership skill development Allen’s (1998) study showed it was
influenced by self-confidence and risk taking as an associated behaviour.
Perhaps risk taking by nursing leaders could have referred to their
unconditionally ensuring nurses had a healthy work culture. In a reversed
perspective, whether nurse executives, as an example, retained their value
links with nursing was noted as a risk by Roberts (1997). Roberts (1997)
claimed that nurse executives may develop their professional identity as a
manager apart from nursing. Further, they may be ‘discouraged from
advocating for nurses and nursing care’ (Roberts 1997:frame 3) because this
could jeopardise their position in the organisation. If such risks were found to be
realised, then, perhaps, the chances for nurse leaders to champion the
inscription of nursing-values and standards as healthy workplaces would also
be in jeopardy. These research findings showed additional research was
needed. There seemed a need to add to the body of knowledge that revealed
real-life strategies that fostered healthy cultures for nurses’ practice. My ethnographic interest incorporated such an aim.

The focus of a Republic of Ireland study was to assess the impact by mid-level health professionals and non-clinicians upon health care organisational culture (Carney 2006). Carney (2006:frame 2 emphasis in original) viewed culture as ‘a critical driver of norms and the “way we do things around here” and plays a powerful and pervasive role in shaping the life of the organization’. Carney (2006) statistically found research participants’ significantly contributed to organisational direction and success in non-profit health organisations. These practices were integral to the culture of the organisation. In my view, Carney’s (2006) study indicated two features. Firstly, it indicated the valuable contribution to an organisation of professional staff in middle-level positions who were integrally involved in the corporate agenda. Secondly, and more disconcertingly, measurement featured as integral to the meaning of organisational culture. Measurement, therefore, shaped the working life and all its potential punitive ramifications. Measurement, as a cultural indicator, was in my view, more aligned with managerialism as a dominating discourse within health care organisations over that of health professionals’ patient-centred values. These notions I further critique in section five of this chapter.

The above discussion alerted me to an opportunity to locate my research interest on inter-nurse relationships partially from a Foucaudian power/knowledge perspective and partially as integral to workplace cultural issues.

Concerns related to the roles experienced by nurse executives, as leaders of hospitals, is further critiqued in section four of this chapter.

In the next sub-section I review literature that exemplified strategies shown to positively affect healthy inter-nurse relationships. These notions were also relevant within the context of my research interest.
Mentoring as Empowering Nursing Leadership

The literature and research critiqued in this section are listed in Table 15. Literature and Research related to ‘Mentoring as Empowering Nursing Leadership’.

Table 15. Literature and Research related to Mentoring as Empowering Nursing Leadership.

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<thead>
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<td>2006b</td>
<td>Maak &amp; Pless</td>
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<td>2005</td>
<td>Hyrkäs, Applequist-Schmidechner &amp; Kivimäki</td>
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<td>2005</td>
<td>Ronsten, Andersson &amp; Gustafsson</td>
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<td>2004</td>
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<td>2004</td>
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<td>2004</td>
<td>Nelson, Godfrey &amp; Purdy</td>
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<td>2004</td>
<td>Nickitas, Keida, Nokes &amp; Neville</td>
</tr>
<tr>
<td>2003</td>
<td>Koukkanen &amp; Katajisto</td>
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<tr>
<td>2002</td>
<td>Brown</td>
</tr>
<tr>
<td>2002</td>
<td>Clare, White, Edwards &amp; van Loon</td>
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<tr>
<td>2002</td>
<td>McMillan &amp; Conway</td>
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<tr>
<td>2002</td>
<td>Norris</td>
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<tr>
<td>2001</td>
<td>Gilmartin</td>
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<tr>
<td>2000</td>
<td>Bakker, Killmer, Siegrist &amp; Schaufeli</td>
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<tr>
<td>2000</td>
<td>Glass &amp; Walter</td>
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<tr>
<td>2000</td>
<td>Malloch, Sluyter &amp; Moore</td>
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<td>1999</td>
<td>Pannowitz</td>
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<td>Curtin</td>
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<td>Davidhizar</td>
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The micro-web of interpersonal relationships for nurses positioned in middle-level health care organisations formed an integral part of my research interest. Thus, my attention was drawn to literature about mentoring as a practice of nursing leadership and enhancement of nurse-nurse relationships. Maak and Pless’ (2006b) description of responsible leadership embodied the features of mentorship, inclusive of building and sustaining trustful relationships, fostering and caring for followers and supporting their development – being partners on a leadership journey.

Inherent within the notions of mentorship was collegiality. Collegiality was a special human ethical relationship among professionals, ‘characterized by exquisite respect for the person of the other’ (Curtin 1995:frame 2). This
description could be interpreted to also mean a promise to nurture each other within the profession so that ‘we give life to our profession’ (Curtin 1995:frame 3). However, one quantitative research found the notion of collegiality was not evident in authoritarian leadership styles and which prevented empowerment among nurses (Koukkanen & Katajisto 2003). The disparity between the notions of leadership style, as proposed by Maak and Pless (2006b), Curtin (1996) and Koukkanen and Katajisto (2003) indicated an opportunity for further research.

There were several research publications and a number of scholarly papers as critiqued below that indicated the value of mentoring as empowering in nursing relationships. These works showed the positive benefits of professional peer supervision (e.g. Glass & Walter 2000). No research was identified that explored the outcomes of mentoring as a structured collegiate practice among or between executive and senior nurses, ideas which I believed indicated a space within which to partially locate my research interest.

The role of mentor was highlighted by Borbasi, Jones and Gaston (2004:175) as someone who ‘passes on useful information and acts as a coach, allowing an individual to learn risk-taking behaviours, communication skills, political skills and specific skills related to the profession’. In a similar comment to that of Glass and Walter (1998), Maak and Pless (2006b:44) asserted that to be an effective mentor, one needed also to be an effective leader and know oneself in order to be ‘authentic and reliable as a leader’.

Hyrkä, Applequist-Schmidlechner, and Kivimäki (2005:frame 8) undertook a three year longitudinal qualitative study with nurses and nurse managers in Finland. They found long-term benefits of improved leadership and communication skills when these nurses participated in peer supervision programs. Although, not directly incorporating the term mentorship or leadership, Mrayyan (2004) undertook a comparative descriptive international internet survey with staff nurses (n = 317). Mrayyan (2004:abstract) found that ‘supportive management, education and experience’ were the three variables most important to increase the nurses’ autonomy. My research interest was not toward identifying specific variables that fostered relationship-building or mentoring. However, my interest was toward understanding nurse’s
experiences of disempowering, empowering, and/or transformative workplace relationships.

The notion of senior experienced people mentoring and coaching juniors was historically an ancient exercise with Socrates being an early advocate and expert. However, it was noted in the literature that nursing leaders may not know how to practise coaching-leadership skills that fostered nurses’ self-esteem and minimised risk of burnout (Bakker, Killmer, Siegrist, & Schaufeli 2000). On the other hand, the novel idea of nurse executives mentoring new graduate nurses to develop their leadership skills was the focus of an American study (Nickitas, Keida, Nokes & Neville 2004). In this particular mentoring project the aim was to engage nurse executives in the clinical field to establish formal learning partnerships within a power-equity relationship with graduates. The initial phase of that study, as reported, found positive benefits for both partners when their mentoring model was used with nursing academic faculty and student nurses in developing their research skills. These research findings were not dissimilar to the assertions by Brown (2002), Lines (2006) and Davidhizar (1995). In one-to-one mentorship relationships with successful nursing leaders Davidhizar (1995:frame 2) stated that ‘secrets of personal success can be shared’ along with enhanced optimism in personal ability.

Nickitas, Keida, Nokes, and Neville’s (2004) study offered a different model to the preceptorship program. Preceptorship, a structured mentorship program, had been successfully exercised throughout WA hospitals since the mid 1980s. It involved a process whereby new graduate nurses were ‘buddied’ with an experienced registered nurse to assist their transition into the ethos and cultural practice setting. The success of this kind of program was affirmed by Coates and Gormley (1997), Ronsten, Andersson and Gustafsson (2005) and by Glass and Walter (2000) in their peer mentoring research with student nurses. The practice of mentorship and preceptorship between nurse executives and middle-level nurse managers was a key recommendation I had proposed at a national nursing management conference in 1999 (Pannowitz 1999). Gilley and Boughton (1996) also incorporated mentoring as integrally important to performance management in which the supervisor, as coach, was responsible for developing a mutually trusting relationship with their subordinates. Other
literature reviewed also supported preceptorship and or mentorship as techniques that fostered sharing of expertise, learning, performance support, career development and other localised collegiate benefits (Clare, White, Edwards, & van Loon 2002; McMillan and Conway 2002; Nelson, Godfrey and Purdy 2004; Norris 2002;).

Inclusive of values inherent in the concept of mentorship was Malloch, Sluyter, and Moore’s (2000) reported success among American health professionals and administrators who participated in relationship-centered care programs. They suggested that this kind of program aimed to ‘restore the fundamental essence of healing relationships in healthcare’ (Malloch, Sluyter, & Moore 2000:frame 1). In a similar vein, Gilmartin (2001) strongly proposed the benefits of contemporary stakeholder management models for nursing and health service management practice. In this model the ‘human condition is celebrated, exemplary service is cultivated, and human caring becomes an enterprise value’ (Gilmartin 2001:frame 1).

The above discussion highlighted the existence in some settings of established and successful empowering inter-nurse models of practice. Caring and collegiality were shown to be values and behaviours present in responsible leadership styles. Mentorship, preceptorship, or relationship-centred practices between nurses was also shown to positively contribute to a healthy and professionally collegiate workplace culture. These kinds of literature and research celebrated the empowering potential within nurses, those people whose professional aspirations were toward caring for others. More research, undoubtedly, was needed that revealed nurses’ voices of empowering practices at the individual nurse level. It was within the interstices of these frames of empowerment that my research interest was especially yet partially located.

The following critiqued research takes a different perspective to the positive practices of fostering healthy workplace cultures and mentoring relationships for nurses. The burgeoning discourse of horizontal violence as specifically involving nurse-nurses’ destructive relationships was important to critique as a potential space to partially locate my research interest related to understanding the lived experience of women nurses.
Nurse-Nurse Violence – Discourse of Overt Oppression

Literature search located an increase in violence experienced by health professionals, patients and relatives, and the severe potential and actual physical and psychological outcomes of this behaviour (Rippon 2000). However, I chose to limit my literature review principally to nurse-nurse violence as located within the oppressive and/or disempowering discourse.

The literature and research critiqued in this section are listed in Table 16. Literature and Research related to ‘Nurse-Nurse Violence – Discourse of Overt Oppression’.

Table 16. Literature and Research related to Nurse-Nurse Violence – Discourse of Overt Oppression.

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<td>Taylor</td>
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<td>McCall</td>
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The recognition of the widespread existence of horizontal violence within the community of nurses was revealed by a plethora of research (Farrell 2001; Freshwater 2000; Glass 2007, 2003a, b, c, 2002-2003, 2001a, b, c, 2000, 1998, 1997, 1994; Glass & Davis 2004; Hegney, Plank & Parker 2003; Jacoba 2005; McCall 1996; Rippon 2000). Literature showed the traumatic and devastating personal impact upon nurses who have experienced workplace bullying. Workplace bullying was noted as not unique to the nursing workforce. Of workplace bullying, Hutchinson, Jackson, Vickers and Wilkes (2006:frame 2) highlighted, ‘it is not a one-off, or accidental event: instead, it is a deliberate and ongoing array of often subtle and masked negative behaviours and actions that accumulate over time’. Because of the pervasiveness of horizontal violence as a nursing experience this emergent disempowering discourse, situated in the cultural context of nursing and health care organisations, was important to
review to affirm a possible gap in knowledge within which my ethnographic interest could contribute to the dialogue.

Hutchinson, Jackson, Vickers and Wilkes (2006) referred to extensive research and literature which described bullying as horizontal violence among nurses within the oppression narrative. This finding was not dissimilar to Taylor’s (2001) Australian action research with registered nurses. Taylor (2001) referred to horizontal violence, also known as mobbing, which was found to lead to experiences of powerlessness. The violence was found to be a sociopolitical symptom but directed toward colleagues. Hutchinson, Jackson, Vickers and Wilkes’ (2006) review demonstrated that horizontal violence among nurses was a taken-for-granted phenomenon. They also claimed that ‘nurses are doubly oppressed through gender and medical dominance’ (Hutchinson, Jackson, Vickers & Wilkes 2006:frame 3), as had Glass (1998) who termed this a ‘double whammy’. Hutchinson, Jackson, Vickers and Wilkes (2006) took the view of this phenomenon into Foucauldian circuits of power model to critique bullying within the broader organisational arena. Their discussion included consideration of potential upward and downward bullying and the inner workings of the organisation as alternate understandings of bullying upon nurses (Hutchinson, Jackson, Vickers & Wilkes 2006). Further, they drew from Speedy (2004) to note that the perpetuated violence evident in the workplace focused upon efficiency and cost constraint and described it as a form of ‘organisational violation’ (Hutchinson, Jackson, Vickers & Wilkes 2006:frame 5).

On violence among nurses, as another example, Hutchinson, Jackson, Vickers and Wilkes (2006) noted that Hockley’s (2002) research described the consequence of bullying upon nurses who breached organisational rules as an act to reinforce established behaviour. Thus, bullying was strategically used to maintain order. Further, the person being bullied was viewed as the problem! Their critique showed the possibility for understanding nurse-nurse oppression as an abusive and perpetuated power-play within organisations (Hutchinson, Jackson, Vickers & Wilkes 2006). These oppressive practices were especially evident by the experiences of Toni Hoffman, the Australian registered nurse who was the whistleblower on Dr Jayant Patel, dubbed Dr Death by the media (Nursing Review 2006). In 2005, bullying by executive staff toward Hoffman, in
one of Queensland’s public hospital, inclusive of the DON, was notoriously exemplified in their lack of support and oppressive treatment of her. Hoffman, independently, breached the typical silence of nursing by speaking out, bringing the State government and the Department of Public Prosecution’s attention to an international criminal scandal. This nurse’s oppressive experience by her own nursing executive, in particular, brought high public media attention that violence toward nurses by nurses within Australia was not an illusion.

Hoffman’s nursing experience was not unique. This could be demonstrated by the isolation and betrayal by the medical fraternity experienced by Dr Gerard McLaren in the early years of 2000. Dr McLaren was the whistleblower against a neurosurgeon in the Australian Capital Territory for incompetent practice (Masters 2007). This revelation was one of the Australian Broadcasting Corporation programs, *Australian Story*, televised on Monday 27th August 2007. Dr McLaren voiced his understanding of why he was ostracised: whistleblowers undermine trust and credibility by hospital administrators and thus are too risky to stay or be employed in their hospital. One positive outcome of this whistleblowing episode was significantly improved and safer systems within that hospital. Putting the patient first, literally, was shown to have devastating personal and professional consequences for health professionals who speak out and acted upon their ethical values and obligations.

The evidence of inter-nurse oppressive practices, as shown by the research and literature noted above, formed a component of my research interest. In particular, I was interested to understand, from a feminist postmodern perspective, how nurses in middle-level hospital positions self-managed experiences of oppressive practices, if these existed, by their senior nurses and other senior staff. However, further literature review within the discourse of nurse-nurse violence was important to identify a space within which my research interest could be located. Of particular importance to my research interest was the scholarly work of Freshwater (2000) and research conducted by Glass (2007, 2003a, b, c, 2002-2003, 2001a, b, c, 2000, 1998, 1997) and Glass and Davis (2004), which is critiqued below.
The causal determinant for nurses’ violence toward each other was framed by Freshwater (2000:frame 1) who asserted that because ‘nurses are dominated (and by implication, oppressed) by a patriarchal system headed by doctors, administrators and marginalized nurse managers, nurses lower down the hierarchy of power resort to aggression amongst themselves’. Freshwater (2000) proposed a nursing education model which aimed to foster the emergence of nurse’s voices, as legitimate nursing power, to uncover and reframe oppressive experiences. Freshwater’s (2000) model of critical reflection and transformative resistive oppressive practices was inspiring. It indicated the possibility to pursue these notions into a practice-based emancipatory ethnographic research design from which nurses’ voices would be foregrounded, like that which I was interested to pursue.

Of workplace violence on women nurse academics, some of whom held concurrent appointments as clinicians, Glass (2007, 2003a, b, c, 2002-2003, 2001a, b, c, 2000, 1998, 1997) brought wide attention with her internationally multi-sited integrated feminist postmodern ethnographic research. Her research included fifty three women nurse academics from university schools of nursing in Australia, New Zealand, United States and the United Kingdom. She highlighted that competition and extensive violence was present within the Australian schools of nursing (Glass 2003b). Further, she found that participants revealed they were not supported or recognised for their workplace contributions. The abuse Glass (2003b) revealed included physical and emotional violence with typical patterns of domestic violence and horizontal and opaque violence. Further, the abused women nurses were concerned that if they disclosed such violence there may be ‘ongoing threats by perpetrators’ (Glass 2003b:189). Glass (2003b:189) coined the terms ‘unsaid, invisibles, hiddens and shadows’ to describe destructive experiences as revealed by the women nurse academic participants. She also described ‘vulnerability and silences as responses to power and control in the workplace’ (Glass 2003b:189). These practice-based terms were revealed by her giving public voice to the women participants’ exemplar experiences.

Of the term ‘unsaid’ and silences Glass (2003b) referred to participants’ voices not being heard, of being deliberately made to feel invisible by exclusion from
decision-making generally and for the school. Each of Glass’ journal publications (2007, 2003a, b, c, 2002-2003, 2001a, b, c, 2000, 1998, 1997) that focused upon workplace violence upon women nurse academics foregrounded participants’ voices of the multiple destructive realities they experienced in their day-to-day working life in the university, and especially within their respective schools’ of nursing. The feminist principle of foregrounding women research participants’ voices as legitimate sites of knowledge was also of relevance to my interest in research methodology.

Glass and Davis (2004) took the notion of vulnerability as related to nurses’ experiences of violence to a different theoretical and analytic level. These nurse researchers (Glass & Davis 2004) innovatively reconceptualised the meaning of ‘vulnerability’ using deconstructive/reconstructive secondary analysis of selected data. Their data was from Glass’ (1997-2004) integrated feminist postmodern international ethnography with women nurse academics. They applied a trifocal analysis: a realist, oppositional deconstruction and postmodern reconstruction, to re-theorise vulnerability as ‘the link between the positive and negative emotional, cognitive, and behavioural oppositions’ (Glass & Davis 2004:85). Glass (1997, 2001a, b) spoke of the women nurse academics feeling safe to speak and name their vulnerability. In the work by Glass and Davis (2004:91) the secondary analytic process revealed that the participants were noted to be mobile subjects who ‘consciously choose to invert the negatively constructed vulnerability as weakness’. As a transformational act the women nurse academics moved through vulnerability to an empowered positive position that sought to achieve personal and professional outcomes. Glass (2007) (as previously discussed in section one of this chapter) and Glass and Davis (2004) noted that the participants moved between negativity and positivity regarding their vulnerability. This movement brought about their ‘conscious realization of the need for nurturing by self and/or others’ (Glass & Davis 2004:91). Glass and Davis (2004:91) further revealed that it was the participants’ ‘movement that resulted in healing, strengthening, and fulfilling personal and professional growth and integration’. No other research was found that foregrounded an alternate and reframed positive nurses’ discourse that opened up the possibility for nurses to challenge and disrupt the taken-for-granted discourse of workplace violence and vulnerability. Further, Glass and
Davis’ (2004) secondary data analytic method invoked optimism from a previously taken-for-granted view of vulnerability as a negative and disempowering state of being. These insights also indicated the value of applying integrated feminist postmodern perspectives to data analysis and supported a space for my research interest. This methodology, as shown by Glass and Davis (2004) had the possibility to reveal alternate and innovative ways of knowledge production.

The trifocal analytic model applied to nursing ethnographic data by Glass and Davis (2004) indicated their approach was unconventional and unique in nursing research methods. The concepts of emancipatory reflection and trifocal data analysis intrigued me as a possible site to locate my integrated feminist postmodern ethnographic research interest. My interest was to explore new horizons to reveal different and new insights of women nurses’ workplace experiences and retain the authentic voices of the participants.

**Summary of Section 3**

In section three I critiqued numerous research and scholarly papers which framed the attention directed toward the value and need for healthy workplace cultures and inter-nurse relationships. The value of mentorship or relationship-centred models of collegiate practice were noted to be positive contributors to healthy workplaces and affirmed from my own nursing career experience. However, the publication of the AACNs’ ‘Standards for Establishing and Sustaining Healthy Work Environments’ (No author, AACN 2005), as an example, indicated that not all was healthy within the practice setting for nurses.

Thus, in a different frame, research and literature was critiqued. In this section I also highlighted the internationally wide-spread existence of disturbing and an alarming propensity for the cultural context of nurses’ work places and inter-nurse relationships to be unhealthy. Further my literature review and critique highlighted practice settings for many nurses were also oppressive and inter-professionally destructive.

There was a deficiency of research which actually explored empowering strategies nurses’ self-created in order to function on a day-to-day basis; this
was where my research interest was especially located. However, the methodological analysis by Glass and Davis’ (2004) resonated particularly with my own methodology, and offered a partial location for my research interest. Their research upended the negative experience of vulnerability to that of an empowering self-managing strategy by nurses. Further, their integrated feminist postmodern methodology and trifocal analytic method offered a possibility that important insights could emerge from the voices of women nurses’ experience of being in middle-level position within public hospitals; a focus of nursing research that was not evident within the literature.

In the next section I take a different turn in my research and literature review that focused upon the experiences of nurse executives in health care organisations. Nurse executives were nurses at the top of the professional practice rung and held influential and perceived powerful positions. The plight for this un-unified group of nurses was identified to be fraught with difficulties, professionally isolated and predominantly a disempowered position.

Section 4. Tensions Identified at the Nursing Executive Level

Introduction to this section
A number of qualitative and quantitative studies were identified that related to various tensions executive nurses experienced, such as Cameron and Masterson (2000), Irurita (1990), and Lewis (2001). My intention to review literature and research about this level of nurse related to my research interest that concerned the micro-politics of inter-nurse relationships of nurses in middle-level positions, as a network of power relationships. Thus, it was important that I reviewed research which may already have revealed insights of the nature of relationships experienced by nurses in executive and middle-level positions. A search revealed that the impact upon nurses in middle and lower levels of the nursing hierarchy, when their more senior nurses had experienced disempowering experiences, was poorly evident in the literature.

There were relevant insights from research reports that involved nurse executives which related to inconsistencies in leadership skills and styles. Of relevance were research findings that suggested nurse executives did not value
or valorise what they did positively for themselves or for the nursing profession. This literature supported a gap in knowledge within which I could partially locate my research as it related to my interest to understand the network of power/knowledge relationships experienced by nurses in middle-level positions.

The following four sub-sections critique research and literature that focused upon nurses in executive roles in health care organisations. In the first sub-section I draw upon several research reports that showed nurse executives’ models of practice was predominantly that of disempowerment.

**Nurse Executives’ Disempowered Models of Practice**

The literature and research critiqued in this section are listed in Table 17. ‘Literature and Research related to Nurse Executives’ Disempowering Models of Practice’.

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<thead>
<tr>
<th>Year</th>
<th>Author/s</th>
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<tr>
<td>2006</td>
<td>Brandi &amp; Naito</td>
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<tr>
<td>2001</td>
<td>Lewis</td>
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<td>2000</td>
<td>Cameron &amp; Masterson</td>
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<tr>
<td>1999</td>
<td>Wells, Alexander, Piotrowski, Banaszak-Holl, Adams-Watson, Davis &amp; Valentine</td>
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<td>1995</td>
<td>Kippenbrock</td>
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<td>1990</td>
<td>Irurita</td>
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Cameron and Masterson (2000) investigated the impact for nurse executives who were new to their role. Their study emerged as a by-product of an extensive National Health System study in the United Kingdom. Cameron and Masterson (2000:1087) identified that most nurse executives adopted a pragmatic ‘muddling through’ approach to their new role rather. These nurse executives were not supported to implement their professional and service agendas. The lack of structured support for nurse executives was not dissimilar to that noted from two WA grounded theory studies by Irurita (1990) and Lewis (2001) and a Japanese study by Brandi and Naito (2006) with nurse administrators.

Irurita (1990) used grounded theory to establish a nursing leadership theory, related to corporate level nurses in rural WA. The participant’s roles were a
combination of clinician and manager. Irurita’s theory (1990) related to the nurses’ adaptation to and enactment of their clinical management role. She labelled her sensemaking process theory, framed within symbolic interactionist paradigm, ‘optimizing’. Within this frame the executive nurses, women and men, made ‘the best of the situation, making the most effective, or optimal, use of all available and potential resources’ (Irurita 1990:iii). Similar results to Irurita’s (1990) study emerged from a 1995 American study which found the principal professional reasons for executive nurse turnover was attributed to lack of power to make changes, conflicts with the CEO, inadequate nursing staff, and feelings of isolation/lack of peer support (Kippenbrock 1995).

Lewis (2001) also used symbolic interactionist methodology and grounded theory, to study executive nurses, men and women, in WA rural health services whose jobs were also a combination of clinician and management. Lewis (2001) found her cohort lacked role models and mentors and the geographic isolation was both personally and professionally problematic among all participants. She further found that the participants ‘relied on their sensemaking processes in order to explain the ambiguous nature of their practice environment’ and their poorly defined role (Lewis 2001:v). Lewis (2001) drew attention to the antagonistic relationship between the health service agenda and clinical practitioner when these roles were combined. Interestingly, Lewis (2001) noted that the combined management and clinical roles were perceived as complimentary. Brandi and Naito (2006) in their feminist grounded theory study found a similar outcome to Lewis (2001). Brandi and Naito (2006) found no ambiguity by Japanese nurse administrators to enact the values inherent in their role. However, the Japanese nurses’ formal authority was markedly limited to that of their Western counterparts in that nursing budgets had not yet been devolved to them (Brandi & Naito 2006).

Lewis (2001), Irurita (1990) and Brandi and Naito’s (2006) studies provided valuable contributions within the context of my research interest. These studies alerted me to a potential disempowering flow-on effect from nurse executives whose leadership style mirrored approaches like ‘muddling through’ (Cameron & Masterson 2000), ‘optimizing’ (Irurita (1990) and ‘sensemaking’ (Lewis 2001). These projects were not conducted with an emancipatory endeavour. They
were conducted on and not with nurses and which differed to my feminist research interest.

On a more positive note, Wells, Alexander, Piotrowski, Banaszak-Holl, Adams-Watson, Davis, and Valentine (1999) sought to learn how American nurse executives and other members of the hospital executive team perceived the legitimacy of the nurse executive role. Using social identification theory, these researchers drew two principal conclusions. Firstly, they identified that the nurse executives were consistently more positive about their roles than that by associate directors (second level doctors). Secondly, and more unexpectedly, they found that executive physicians and administrators did not minimise nursing legitimacy in clinical or non-clinical decisions (Wells, Alexander, Piotrowski, Banaszak-Holl, Adams-Watson, Davis, & Valentine 1999). Although this study was reported in 1999, in part, it gave credence to the importance of having nurses in executive hospital positions.

In the next sub-section, I extend my critique of literature related to nurse executives which suggested a variety of desirable personal and professional characteristics for effective nurse executives.

**Framing Nursing Executives Leadership Traits**

Reviewing research related to contemporary discourses in nursing leadership was pertinent to ascertain what knowledge gaps existed in relation to my research interest. My research interest did not directly incorporate perspectives of leadership. However, one of my assumptions was that nurses in senior employment positions were leaders, that was, their position within a bureaucratic hierarchy formally located them above other nurses, irrespective of personal characteristics or expertise. Only several research are discussed below because, in my view, the traits emergent from these kinds of studies suggested personal characteristics and behaviour which were not new. Rather, they represented respectful human-human communications and were, therefore, not unique to nursing. One anecdotal report (Wolf 1990) is presented as it related to a nurse executive’s commitment to nursing values and not that of personality traits.
The literature and research critiqued in this section are listed in Table 18. Literature and Research related to ‘Framing the Nurse Executives Leadership Traits’.

Table 18. Literature and Research related to Framing the Nurse Executives Leadership Traits.

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<tr>
<td>2002</td>
<td>Dahlen</td>
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<td>2002</td>
<td>Wieck, Prydun &amp; Walsh</td>
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<td>1997</td>
<td>Morrison, Jones &amp; Fuller</td>
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<td>1995</td>
<td>Dunham-Taylor</td>
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<td>1990</td>
<td>Wolf</td>
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Of note, was Vance and Larson’s (2002) findings from an extensive computerised search and review of leadership in health and business. They noted that the majority of literature was anecdotal or theory based with minimal outcomes-based research focus.

The reduced labour pool for nurses in the United States and the risk of a lack of nursing leaders in the future was the impetus for Wieck, Prydun and Walsh’s (2002) study. This quantitative study sought to identify what traits newly graduating nurses valued most of their leaders. Of the findings, honesty was the most important characteristic and having empowering leaders. Without practical nursing leadership exemplars of the identified personality attributes, the findings from this study were almost meaningless.

Dunham-Taylor (1995) used structured interviews with selected nurse executives to reveal similar characteristics to those by Wieck, Prydun and Walsh (2002). Dunham-Taylor’s (1995) finding contrasted with those by Dahlen’s (2002) Californian quantitative survey with nurse manager respondents (n=32). What was missing, as one example, was ‘using power to serve others’ (Dahlen 2002:abstract). The tensions between these study findings indicated potential inter-nursing hierarchical relationship problems, notions which were integral to my research interest.

In a rural American health service Morrison, Jones and Fuller (1997) surveyed nurses, including nurse executives (n=275). They explored the tripartite topic of
the relationship between leadership style (transformational and transactional), empowerment and nurses’ job satisfaction. Their findings indicated that both leadership styles were positively related to job satisfaction but with a stronger correlation with transformational leadership. Transformational leadership was positively related to empowerment; and empowerment was positively related to job satisfaction (Morrison, Jones & Fuller 1997). The study, like many similar types of job satisfaction surveys, provided interesting information and support for transformational leadership. However, in the conclusion, these researchers did not advocate for a particular program, instead they claimed ‘it is important that executives not use one narrowly focused intervention program’ (Morrison, Jones & Fuller 1997:frame 8). Such a disclaimer had the potential to negate the purpose and value of the study.

Concerning her role as Vice President Nursing Administration, Wolf (1990) commented from a non-personality trait perspective anecdotal professional values. Wolf (1990:10) asserted that ‘our most significant power base lies within our clinical expertise’. She acknowledged leadership of nursing as the principal responsibility of her executive function. Her concern related to the risk that nurses in executive positions ‘are often seduced into minimizing it [nursing]’ (Wolf 1990:10). Almost ten years earlier, Clifford (1981) urged nurse leaders and nurse administrators to integrate their professional and corporate agenda responsibilities. More significantly, Clifford (1981:21 emphasis in original) strongly advocated that nursing leaders must maintain their identity as ‘nurses if they are to develop appropriate mechanisms for assuring control of nursing practice, public accountability, and protection of the accountability of the individual practitioner’. Wolf’s (1990) personal views and Clifford’s (1981) assertions epitomised the triple-edged tension for nurse executives between retaining their nursing values, risking transgressing to a different set of values that were not complimentary for the nursing profession, or finding self-managing strategies to effectively articulate both roles. Further, these authors’ comments made no reference to personal characteristics but rather to embedded values and identity of nursing.

The tension between reported desirable leadership personal traits and values indicated a gap in nursing knowledge. My research interest was more toward
revealing the enactment of values in practice rather than explicating already identified effective or non-effective leadership personality traits.

Research that related to tensions for nurses in middle-level health organisations is critiqued in the next sub-section. This literature referred to organisational structure as particularly negatively impacting upon nursing practices. One of my assumptions was that organisational culture was influenced by organisational structure in respect to the power/knowledge relationships between different levels of staff and especially as this related to middle level nurses, the critique of which was part of my research interest.

**Middle-Level Nurses – Betwixt and Between**

In reviewing the literature it was of particular interest to my research focus to explore evidence of reported experiences of middle-level nurses in their enactment of their roles. My literature search identified that for this level of nurse there was no harmony between their corporate agenda and nursing responsibilities or the culture and organisational structure. However, this level of nurse was identified as the critical link between achieving patient care needs and the corporate agenda (Aroian, Horvath, Secatore, Alpert, Costa, Powers, and Summer-Stengrevics 1997; Oroviogoicoechea 1996). For this group of nurses, considered as leaders (Alexander 2000; Patz, Biordi, & Holm 1991), they were also noted to have a ‘Herculean task to perform’ (Manfredi 1996:frame 9). The literature critiqued below was relevant because it revealed an opportunity to critically explore to deeper levels the experiences of middle-level nurses than that which had been reported in research over the past ten years.

The literature and research critiqued in this section are listed below in Table 19. Literature and Research related to ‘Middle-Level Nurses – Betwixt and Between’.
Table 19. Literature and Research related to Middle-Level Nurses – Betwixt and Between

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<td>2005</td>
<td>Murphy</td>
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<td>2005</td>
<td>Suominen, Savikko, Puukka, Doran &amp; Leino-Kilpi</td>
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<td>2000</td>
<td>Stordeur, Vandenbergh &amp; D’hoore</td>
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<td>1999</td>
<td>Laschinger, Wong, McMahon &amp; Kaufmann</td>
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<td>1999</td>
<td>Persson &amp; Thylefors</td>
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<td>1997</td>
<td>McNeese-Smith</td>
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<td>1996</td>
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Manfredi (1996) in her American study with experienced women nurse managers ($n = 42$), described the congruence between how middle-level nurse managers operationalised seven leadership concepts. However, in practice, Manfredi (1996) found the participants had minimal input or influence upon organisational goals, change, growth and vision. However, they were required to sell these notions to staff and convince them that they had control over how these could be accomplished at the local level. The study indicated that the participants were required to interpret the corporate agenda to fit with the local unit focus. The discrepancy between perceived leadership characteristics and actual practice for Manfredi’s (1996) respondents indicated the existence of double-edged and dichotomous contexts of practice. On one hand a corporate agenda in which they had no input; and on the other, their middle-level responsibility to unquestioningly enact the corporate agenda. The study results did not report upon how the respondents dealt with the discrepancies between perceived and actual leadership responsibilities. Rather it identified tensions in the role. My research interest was to endeavour to reveal self-managing strategies for nurses whose roles also combined potentially discrepant corporate and professional responsibilities.

Further tensions for nurses in middle-level roles were identified by Roach (1994) who found this level of nurse was highly susceptible to burnout because of their role conflict. What Roach (1994) highlighted was the tension between their administrative functions and the need to exhibit clinical expertise. Among Roach’s (1994) recommendations to minimise burnout was the need for improvements in the relationships between administrators (presumably nurses
in senior management positions) and nurses. Such disempowering experiences and consequential recommendations were not dissimilar to the literature critiqued in section one (Glass 2007), section two (Wesorick 2002), and section three (Bakker, Killmer, Siegrist, & Schaufeli 2000), as examples.

Perhaps one basis for negative manager behaviour could be understood from the small Swedish study with executive and middle-level nurses, conducted by Persson and Thylefors (1999). These researchers found that work-overload for the participant nurses was a major cause for their dissatisfaction and which may, therefore, have influenced their behaviour toward subordinate nurses. Such results were similarly revealed by Ogle (2004) as critiqued in section one. Perhaps, also, further critique could have added confidence to Murphy’s (2005) recommendation for the development of an empowering competency of ‘management of self’. However, in order to develop a competency of this nature there was a need to more explicitly reveal what that practically meant. Such a gap in knowledge was a possibility to contribute to this dialogue, as inherent within my research interest.

In 2000 a Flemish nursing leadership quantitative survey was undertaken (n = 450) with nurses in varying hierarchical levels across 8 hospitals (Stordeur, Vandenberghe & D’hoore 2000). The principal finding was that there was no cascading effect of transformational and transactional leadership in nursing departments. These researchers speculated that one potential reason for this unanticipated finding was the highly regulated management constraints (in structure and culture) within Flemish hospitals. They noted that these constraints may also have limited transformational leadership role modeling by nurses. The study, however, did not report upon exemplar practices used by those few transformational nurse leaders and thus limited what practical nursing knowledge was gained from the study.

One empowerment focused research related to middle level nurses was a Finnish study (Suominen, Savikko, Puukka, Doran, & Leino-Kilpi 2005). Statistical analysis (n =154) focused on survey items related to job satisfaction, experience of stress/work fatigue, importance of job autonomy, and other clustered work features. Broadly, the findings identified that middle-level nurses’
experienced verbal empowerment but minimal influence at organisational level. In a similar vein, Patrick’s (2006: frame 7) Canadian statistical study of perceptions about structural empowerment and organisational support from nurse managers (n = 84) found links between respondents feeling valued by the organisation when they received positive feedback and recognition of innovative practices. These studies were insightful of the disparity of actual power middle-level nurse managers experienced within the cultural context of their practice.

In an earlier Canadian study Laschinger, Wong, McMahon and Kaufmann (1999) surveyed nurses (n = 537) using Kanter’s organisational empowerment theory. They found that subordinate nurses felt empowered, by association, when their managers were influential. In contrast, it was also found that nurses felt powerless when they could not access the organisation’s decision-making structures. Managers who were ‘controlling, rules-minded, rigid, and territorial’ were identified by nurses as possessing demotivating characteristics and behaviours (Laschinger, Wong, McMahon & Kaufmann 1999:37). From the perception of practising teachers and nurses Helge’s (2005) Norwegian study identified these professionals wanted their managers to motivate and encourage them. In my view, what would have been of practical value to emerge from these kinds of studies would be exemplars of how the nurses responded, accommodated or resisted management practices that were demotivating and/or empowering, such as that by McNeese-Smith (1997) as described below.

An American study (McNeese-Smith 1997) conducted in a metropolitan hospital sought to understand what behaviours positively and negatively influenced their nurses’ levels of job satisfaction, productivity, and commitment to the organisation. The descriptive study utilised structured interviews with nurses (n = 30), 28 of whom were women. The principal positive behaviours identified were: ‘providing recognition and thanks, meeting nurses’ personal needs, and helping or guiding the nurse, using leadership skills, and meeting unit needs and supporting the team’ (McNees-Smith 1997:49). Other positive manager behaviours included trusting staff, teaching, being passionate about nursing, role modeling, and active listening. These attributes were exemplified by comments such as: ‘being on our side, willingness to bat for the employees’
Dissatisfying manager behaviours focused on lack of recognition, poor follow-through with identified problems, and minimal help with heavy patient loads. What emerged from this study was that the identified positive behaviours related to empowering relationships between hierarchical levels of nurses that enhanced nurses’ job satisfaction and organisational commitment. In contrast, negative behaviours encompassed the potential for disempowering experiences for the nurses. McNeese-Smith’s (1997) study indicated an opportunity for further research. By taking the emergent notions into a critical feminist postpositivist research arena, it was also possible to elucidate the impact upon nurses’ inter-professional relationships.

In the context of my ethnographic interest, the above studies indicated a gap in knowledge related to the possibility for a deeper level of critique of the cultural construction of the effects from Foucault’s (1980) power/knowledge relationships concepts and those from feminists’ critique of patriarchal dominance.

The next sub-section critiques research relevant to my research interest which focused upon revealing self-managing strategies doctors enacted as they transitioned into managerial roles. No research was found that focused upon or applied similar methodology to nurses. My research interest focused upon nurses’ self-managing strategies as they enacted their middle-level roles.

**Experience of Transitioning into Management – How Doctors Do It**

Included in this sub-section is a brief discussion of research conducted by Forbes and Hallier (2006). Their research findings referred to self-managing strategies used by doctors who were transitioning into medico-management roles. I disagreed with these researchers’ suggestion of the possibility that their findings could also be suitable for nurses.

The literature and research critiqued in this section is listed in Table 20. Literature and Research related to ‘Experience of Transitioning into Management – How Doctors Do It’.
Forbes and Hallier’s (2006) Scottish based study was among the only international study identified that sought to understand the localised strategies clinician health professionals developed during their transition into management roles. These researchers’ interest was to overlay findings from interviews with doctors onto possible implications for nurses in similar transitions experiences. The study, conducted over a five year period, 1999-2003, included a cohort of 18 doctors who were interviewed and data analysed by comparative grounded theory (Glaser & Strauss’ model) framed within a social psychological identity theory. The purpose of the research was to explore the ways individual clinicians ‘tackle and assign meaning’ to their new roles as managers (Forbes & Hallier 2006:frame 2). Also they sought to understand why they moved into the role, experiences of the transition, expectations perceived/achieved of the role, conflicts and ambiguities experienced in the transition.

From Forbes and Hallier’s (2006:frame 2) research two social identity types emerged: ‘reluctants’ who felt pushed into the role; and ‘investors’ who had chosen to move into the role. In respect to the two group’s responses to more senior doctors’ management transgressions, they showed different self-creativity strategies. The ‘investors’ adopted a protective rationalised identity; whereas the ‘reluctants’ made no similar rationalisation but instead distanced themselves from higher management and resorted to their clinical role and values. Also, as noted by Forbes and Hallier (2006), unlike nurses in middle-level positions, their research participants had the autonomy to legitimately absent themselves from managerial responsibilities by their inflation of importance to meet their clinical responsibilities.

Forbes and Hallier’s (2006) research was an important contribution to the knowledge base for understanding local experiences for doctors moving into managerial roles. Their insights could have beneficial implications for consideration by the nursing profession. However, I was not convinced that the findings could be easily transferred across to nursing, especially because of the

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significantly contrasting ways doctors and nurses were identified to enact their professional autonomy and organisational responsibilities. Forbes and Hallier (2006: frame 9) urged the need for empirical studies with clinician nurses transitioning into management roles. I contend that my ethnographic interest was a timely response to such urgings but with a different cohort, method and theoretical framework.

**Summary of Section 4**

In the above section of this chapter, a variety of discourses were critiqued as these were shown to particularly influence nurse executive and middle-level nurse managers. By revealing disturbingly disempowering experiences of nurses in executive hospital roles, through to lists of perceived effective and disempowering leadership characteristics and behaviours, the literature I reviewed indicated the culture within which these levels of nurses function was fraught with competing and different tensions. Of the literature reviewed, minimal realist exemplar practices foregrounded the research results. Thus, there were limited opportunities for transformative practices to be recognised by nurses in their practice setting as potentially pertinent to them. Although the above research was practice-focused the results were predominantly theoretical suggestions. From a different perspective, Forbes and Hallier’s (2006) critique which identified self-managing strategies applied by doctors as they transitioned into management roles was enlightening and of particular relevance to my research interest, (but with nurses). Forbes and Hallier’s (2006) findings and recommendations, along with other literature and research critiqued in this section, provided a space within which my research interest could be confidently located.

In the next section, literature and research is critiqued which related to the rationalist economic discourse of managerialism. This new dominant discourse was evident in the business model of public hospitals. In particular, my critique related to how managerialism in hospitals had impacted upon nursing. Critique of this discourse was also important to locate the possible knowledge gap within which my research interest could be positioned.
Section 5. Managerialism - the New Health Economics Discourse

Introduction to this section
Discussed in this section is literature and research that related to the marked change in the cultural context of public health organisations. The change was in the form of shifts from medical dominance to the new discourse of economic rationalism, or managerialism. This change represented a form of modernism which had sought to ‘order, predict and control the material world through the rational application of scientific method’ (Newbold 2005b:frame 1)

The impact of managerialism upon nurses and the nursing profession in Australia and United Kingdom (countries with similar health system structures and operations), had attracted important research to date. One United Kingdom scholarly paper and an American nursing research project were identified which had important implications for the Australian context. From my literature search, it became clear that health professional groups were negatively impacted by this governmental shift in agenda from patient care to patient economics. In addition, as Maak and Pless (2006a) had highlighted, there were ethical problems in the shift toward managerial pragmatism and its relationship to leadership.

My research interest was embedded within the construct of corporate agenda and nursing professional practice. Therefore, it was crucial to focus my literature search within the discourse of managerialism to locate the possibility of a gap in knowledge which could support my research interest. Public hospitals were being re-organised to align with private sector business models. The cultural context for health professionals, inclusive of nurses, was shown to have altered. What it meant to function within multiple and competing discourses, such as that of medical and managerial discourses, was identified as a site for increasing focus for nursing research and an aspect inherent in my research interest.

There are two sub-sections that form this section of this chapter. In the first sub-section, below, features comprising the emergent managerialist discourse are
presented. Literature and research is then critiqued which demonstrated the shift for public institutions, like that of hospitals, from the dominance of medical discourse to that of managerialism and its impact upon professionals. In the second sub-section literature and research is critiqued which highlighted the negative impact of managerialism upon the care value of nursing and nursing labour. Emergent from the critique presented in these sub-sections was an identified need for further research, like that of my area of research interest.

**Hospitals as a Business – Shifting Discourses of Dominance**

Below is presented literature and research which affirmed the agenda of public health systems in the Western world, including Australia, had shifted from patient-centred to funding-centred. This discourse was shown to have significant ramifications upon the nursing profession. The full impact upon nursing practice had been relatively recent (please refer to Ogle 2004 in section one of this chapter and Orrock & Lawler 2006 in the previous chapter).

The literature and research critiqued in this section are listed in Table 21. Literature and Research related to ‘Hospitals as a Business – Shifting Discourses of Dominance’.

Table 21. Literature and Research related to Hospitals as a Business – Shifting Discourses of Dominance

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<td>2005</td>
<td>Gilbert</td>
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<td>Newbold</td>
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<td>2005</td>
<td>Mannion, Small &amp; Thompson</td>
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<td>Brewer &amp; Lok</td>
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<td>1994</td>
<td>Barker &amp; Young</td>
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<td>1991</td>
<td>Exworthy &amp; Halford</td>
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<td>1971</td>
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<td>1983</td>
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Barker and Young’s (1994) assertion that most hospitals were still structured in a hierarchy from the top down reflected the current situation in Australian public hospitals. This bureaucratic organisational structure was not dissimilar to that of the traditional Weberian designed bureaucracy (Weber 1947 in Pugh 1971). Turkel (2001:frame 1) reinforced that ‘hospitals are a business first’. Even the language was changing within hospitals to that of products and commodities (Gleeson & Low 2000). Newbold (2005a) described the new health economics, or managerialism, as a rapidly developing discipline especially influencing health care practices, including that of nursing and nursing management. Edwards’ (1998) notions affirmed managerialism’s focus was toward four values: economic efficiency; faith in the tools and techniques of management science; top-down class consciousness which serves as a unifying force among managers for the benefit of organisational wellbeing (hierarchy and control); and managers as utilitarian moral agents. Gilbert (2005) also argued that the professional’s context of trust was being redefined by managerial imperatives of distrust, such as that of audits and quality monitoring. Exclusive of the concepts outlined by Edwards (1998) were professional expertise and values and the potential dualism of the competing values between professional (such as a nurse) and management. Such changing cultural discourse influences upon nurses in middle-level public hospital positions framed a part of my research interest in respect to their personal, professional and corporate day-to-day responsibilities.

Of public organisations, such as hospitals in the United Kingdom, Australia, New Zealand, Canada and other Western economies, Powell, Brock, and Hinings (1999) highlighted the undermining of professional dominance as a consequence of increased government pressure toward the competitive market. Professional bureaucracies, like hospitals, to achieve efficiencies had been required to shift to corporate management practices. Powell, Brock, and Hinings (1999) drew references from 1960s and 1970s in the field of archetype hospital bureaucratic cultures to highlight the historicity of medical dominance. Managerialism had become a challenge to the traditional ways of doing business (Denis, Lamothe, Langley, & Valette 1999; Halford & Leonard 1999; Powell, Brock, & Hinings 1999). Exworthy and Halford (1999) noted that managerialism risked creating conflict between managers and professionals.
Whereas, Robertson (2005) went further to express deep concern that managerialism threatened democracy. However, Brock, Powell, and Hinings (1999) claimed that along with managerialism, professionals retained their traditional values and practices.

The governance of public sector organisations was changing remarkably (Gleeson & Low 2000). A multi-professional model was introduced which sought to improve efficiency, minimise tensions between management and clinicians and engage the key clinicians in managing the business of the hospital. This shift was a theory ‘based on a somewhat innocent assumption that management was a matter of common sense’ (Alexander 2000:165).

Gleeson and Low (2000) explored the governance shift toward managerialism in the Australian public sector, including that of public hospitals. It was within this kind of market-oriented work setting in which nursing leaders in executive and middle-level positions in Australian public health system also became embedded. Such a situation starkly contrasted with how Mintzberg (1983:205), more than twenty years ago, viewed professionals in professional bureaucracies as being ‘constrained only by their established standards of his (sic) profession’.

Caronna and Scott (1999) studied the turbulent changing nature of a large American hospital’s professional and corporate governance over a period of fifty years. They identified that up until the mid-1960s, the dominant agents of governance within most non-profit hospitals in America were the health/medical professionals. Major conflicts between medical professionals and lay administrators eventually led to agreement for formal roles in decision-making of both groups at the corporate hospital governance level. The struggles that emanated from the medical professionals’ interests were to ensure their professional identity and autonomy was protected and not subjugated to corporate control (Caronna & Scott 1999). These kinds of corporate governance conflicts could be assumed to be similar to the Australian public hospital system. Noticeably, there was no mention of whether nurse leaders formed part of this governance shift at the corporate level. The lack of recognition of nurses’ contribution to the emergent economic focus of hospitals indicated a
continuance of the powerlessness historically experienced by nursing, as discussed in earlier sections of this chapter. It cannot be assumed that the impact of managerialism upon the medical profession would be similar for the nursing profession. On the contrary, one might assume that nurses in such situations would experience a continuance of powerlessness and subjugation, but double-fold.

The literature and research critiqued above showed a potential space within which my research interest could be positioned. My research interest was partially toward revealing, at the macro-level, the meaning middle-level nurses’ attributed to their experiences of empowerment, disempowerment and/or oppression within the cultural construction of their practice environment. The literature was showing that managerialism had emerged as another important discourse present in the day-to-day cultural context for nurses in senior positions. My interest was also toward revealing what it meant for them, at a personal, professional and corporate level, to practise within the complexities of multiple discourses present in their practice culture. The following critique of three studies highlighted a paradox confronting nurses within contemporary hospitals. However, these did not adequately address aspects of my research interest.

Of problems confronting health care organisations, globally, Glouberman and Mintzberg (2001), similar to Wigens’ (1997) British nursing study findings, identified a paradox for nurses. They asserted that nurses ‘often get caught between the physicians who claim responsibility for the patients, despite their absence, and the managers [administrators] who claim responsibility for control, despite their distance’ (Glouberman & Mintzberg 2001:61). To add to the paradox, Brewer and Lok (1995) identified that nurse manager’s expertise was underutilised by Australian hospital administrators. Notions of nursing disempowerment seemed to have been especially evident in these kinds of research. Understanding how nurses self-managed being in such difficult situations was lacking.

Mannion, Small, and Thompson (2005) explored how the discourse of health economics in the United Kingdom could become influential in another, such as
in nursing management. They sought to understand, from a Foucauldian perspective, the reciprocal relationship between power and knowledge. They questioned, ‘How are our assumptions about what is possible and desirable shaped, how far do mechanisms of surveillance and self-subjugation extend?’ (Mannion, Small, & Thompson 2005:frame 1). They suggested the need for nurses to critique the underlying assumptions that were often unquestioned in order to consider alternate ways of thinking and practicing. An equally pertinent feminist challenge would have been to ask: What are nurses saying, not saying, and doing to resist being inscribed by this dominant discourse? These kinds of critically reflective questions aligned with my research interest but to take Mannion, Small, and Thompson’s (2005) invitation further. My research interest was to reveal resistive and productive strategies, as potential sociopolitical actions, by middle-level hospital nurses of underlying taken-for-granted subjugating assumptions that negatively impacted upon their practice.

Traynor’s (1999) postmodernist text, *Managerialism in Nursing*, was pertinent to the critique of managerialism. Traynor’s (1999) text emerged out of a research project established by Britain’s Royal College of Nursing as a response to significant British National Health System community health services reforms in the early 1990s. Traynor (1999) highlighted that the reforms aimed to improve services by increasing accountability and cost-containment. Traynor’s (1999) research aimed to understand the impact of these reforms upon community-based nurses’ job satisfaction and morale. Of the nurses in Traynor’s (1999) research it was revealed that they privileged their caring values over that of finances. However, Traynor (1999) cautioned the risk for nurses who took up management positions in the pursuit of maintaining effectiveness for nursing practices. The risk related to such nurses being redefined and controlled by the essentials of managerialism. In other words, nurses could become inscribed by the values inherent in managerialism and forsake their nursing values. Part of my research interest was to understand the impact upon middle-level nurses of the different value sets embedded in discourses influential to their practice.

The negative impact of managerialism upon nursing is further critiqued in the next sub-section which focused upon the financial value of nursing’s practice value of care. As the final component to my literature and research review, my
critique in this sub-section further highlighted that nursing was a subjugated occupation. Managerialism had entered the agenda for nursing as another dominant and disempowering discourse.

**Indifference to Nursing Care Labour**

The literature and research critiqued in this section are listed below in Table 22. Literature and Research related to ‘Indifference to Nursing Care Labour’.

Table 22. Literature and Research related to Indifference to Nursing Care Labour

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<tr>
<td>2005</td>
<td>Currie, Harvey, West, McKenna &amp; Keeney</td>
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<td>2005</td>
<td>de Ruyter</td>
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<td>2004</td>
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<td>2002</td>
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<td>1999</td>
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<td>1999</td>
<td>Malloch &amp; Porter-O’Grady</td>
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The substantive grounded theory of ‘struggling to find a balance’ (Turkel 2001:frame 1) emerged from a study of the nurse-patient relationship in an American for-profit health care system. With the increased focus on managed care where funding was based upon medical diagnoses and its related formulaic structure, hospital administrators were determining resource allocation within the hospital. Nursing care or ‘the element of human caring is missing from the economic discussion (Turkel 2001:frame 1). Turkel (2001) highlighted that since the 1950’s, hospital administrators and not nurses had been counting the cost of nursing care. However, that counting had become more structured in the mid-1980s with the introduction of medical diagnostic-related groups. The cost of nursing emerged from a system of medically focused patient classification. It was associated with how much nursing time, not care practice, a patient received. Nursing was costed as task-orientated activities and not holistic nursing practice-based, or related to skill mix. Currie, Harvey, West, McKenna and Keeney (2005) undertook an extensive international literature review related to magnet hospitals. They identified the importance of nursing skill mix to quality care and nursing professionalism. Lawler (1999:frame 3), more scathingly, argued to reverse the reading of skill
mix to that of ‘dilution of nursing skills’. Currie, Harvey, West, McKenna and Keeney (2005) noted that most quality assessment tools viewed patient outcomes and not nursing in process.

Turkel (2001) noted that nursing research about the economic value of nursing was not keeping pace with the radical economic changes occurring in hospital funding models. In a similar way, Malloch and Porter-O’Grady (1999:300) also urged nurse leaders to address ‘the lack of economic value for nursing’s relational caring work’. Lawler (1999), in the late 1990s, also highlighted that salary was the principal means of determining the value of nursing service. Turkel (2001) also claimed that although nurses had to contend with doing more for less they struggled with explaining the notion of nursing costs. However, the nurses valued the retention of humanistic caring and compassion (Turkel 2001). Turkel’s (2001) study thus added to the notion that clinician nurses resisted being inscribed by the fiscal discourse of managerialism. However, no mention was made by Turkel (2001) of nurses whose roles included corporate business responsibilities, like that of middle-level nurses.

From a different perspective, but also related to the cost of nursing labour, was a study concerning nurses’ job satisfaction. de Ruyter (2005) studied the employment preferences of the United Kingdom nurses at a time when the National Health System was experiencing high nurse recruitment and retention problems. Many nurses were choosing agency employment rather than government employment. This was a similar situation to that in the Australian public health system (Commonwealth of Australia 2002; DoHWA 2004). de Ruyter’s (2005:frame 2 emphasis in original) findings suggested that ‘nurses are working to avoid “office politic” and increased managerialism’. de Ruyter (2005) also found that agency work-pay was higher, despite increased salaries awarded to permanent government employed nurses. The principal implications from this kind of study was that salary increases, as an incentive, was the proposed answer to resolve nursing workforce issues in the British public health system. What de Ruyter (2005) showed was that financial incentives for nurses was not the answer.
To close this section on a positive note, I refer again to the implementation of the Nursing Hours per Patient Day (NHpPD) industrial order (Nurses WA Government Health Services Exceptional Matters Order C2001/1910 11.02.02). This industrial order was discussed in chapter two. This significant initiative aimed to partially enhance the status of nursing labour and in-part resolve nursing workforce problems in WA. This initiative resulted in marked increases in nursing establishment numbers across many WA hospital wards and units (Mantell, Twigg & Kelly 2005). Nurses came back into the WA public health system as a result of improved workplace practices which gave recognition to the care labour provided by nurses.

I fully supported the notion of improving nurses’ salary and the implementation of the NHpPD industrial order. However, these kinds of initiatives did not seem to go far enough. These actions were reactive to long-standing workforce problems rather than proactive campaigns that inverted the subjugated status and value of the nursing profession. What was lacking in the literature and research surrounding the discourse of nursing labour and the care value were nurses’ voices of what it meant to them to practice within a sociopolitical context that poorly valued them. Further to de Ruyter’s (2005) study, my research interest aimed to give voice to WA middle-level nurses of their experiences as constructed within complex local sociopolitical terrains.

**Summary of Section 5**

The deliberate introduction of economic rationalism into public bureaucracies, like that of hospitals in Western countries, was shown from the literature in this section to have negatively impacted upon nursing and other health professional groups. Only one research project was identified which exemplified strategies that doctors used to adjust to their new medico-managerial role. My critique included a concern that the findings could not necessarily transfer to nurses. Managerialism, as a second dominant discourse, together with traditional medical dominance was shown to negatively impact upon nursing and was integral to my research interest.

Attributing a dollar value to one of nursing’s principal values - care - embedded in practice was shown by the literature discussed above as a critical factor
which had been poorly addressed by nurses. The detriment to nursing, as shown in this discussion, was that it was non-nurses who imposed decisions about nursing practice costs that indicated a lack of appreciation of what constituted holistic nursing care. In addition, the nursing profession had failed to effectively set its own monetary value. Further, even when governments were industrially forced to better resource the nursing workforce there was no corresponding adjustment to the status of nurses or legitimisation of nursing knowledge.

**Summary Comments on the Chapter**

My specific purpose for this chapter was to identify a gap in nursing knowledge within which to locate my research interest. My intent was to critique a broad range of discourses. This was to show the multiple culturally constructed influences impacting upon middle-level nurses. Their day-to-day practice was assumed to encompass explicit and implicit expectations derived from the corporate agenda and their professional nursing values. Their responsibilities, whether in management or clinician expert roles, were thus enmeshed in enacting the strategic and operational corporate objectives. At the same time, being a nurse also located them within their professional frame of practice standards, competencies and values. My literature and research review revealed numerous sociopolitical tensions, as a variety of discourses, which impacted upon this group of nurses. Emergent from these critiques were opportunities for further research, like that encompassing my research interest.

Literature and research pertinent to understanding what had been said about this level of nurse was drawn from the 1990s through to the present. This was necessary because limited recent research was located that provided depth and breadth of knowledge about middle-level nurses’ experiences of practicing in health care organisations. It was important to critique what taken-for-granted culturally constructed assumptions, as discourses, were present in this level of nurses’ day-to-day practice. Further, it was important to critique what had been said about this level of nurses’ experience of the multi-level network of relationships that influenced their practice. In other words, it was relevant to understand what insights had been revealed about nurses in more senior positions and in subordinate positions. As senior staff within health care
organisations, it would be reasonable to have assumed that these nurses would have the status and power to influence health related decisions. However, the literature did not support such an assumption. Thus, it was important to critique research and literature that focused upon the legitimacy and status of nursing power and knowledge. I also sought to locate research and literature that revealed practical, day-to-day examples of the way nurses self-managed the potential and actual tensions present in their work.

An extensive search was undertaken using numerous electronic search engines, and other forms of nursing and related non-nursing publications. My aim was to predominantly locate full-text publications. Although my research interest was located within the WA public hospital context, I sought to critique literature and research from the local, national and international perspectives.

What was explored in this chapter were numerous, different, and at times, competing understandings about nurses’ experience of being a nurse. The greater proportion of my literature review, pertinent to my research interest, was located in qualitative methodologies. Research which incorporated critical feminist and/or postmodern methodologies and methods related to nurses’ experience was also of particular interest to me. My interest was toward locating critical feminist and integrated feminist postmodern studies as these had the potential to reveal nurses’ emancipatory practices and celebrate the ‘de-silencing’ of women nurses’ voices (Glass 2007). No similar research was found that aligned directly with my research interest, although several studies were identified which applied similar methodological approaches within the frame of nursing management and nurse-nurse violence. One identified research had applied a trifocal secondary data analysis to data from a previously conducted Australian research with women nurse academics (Glass & Davis 2004). These research indicated a gap in knowledge related to nursing research methods.

A number of specific Australian research projects were foregrounded because these indicated a potential site within which to locate my research interest. I explored research and literature that highlighted the struggles experienced by nurses that showed the subjugation of nursing knowledge and status. In
contrast to the discourses that revealed nursing subjugation was the emergence of the legislated role of the Nurse Practitioner. This expanded nursing practice role was a form of legitimisation of clinical nursing expertise. However, my critique showed that even nurses questioned whether this role had moved more toward the medical model of practice.

Research and literature that related to healthy workplace cultural contexts revealed a range of recommendations needed to enhance an empowering and satisfying workplace culture for nurses for instance. The publication of the AACNs’ ‘Standards for Establishing and Sustaining Healthy Work Environments’ (No author, AACN 2005) brought into question inter-nurse caring practices. Critique of the health of workplace cultures was a lead in to critique the more troubling discourse of nurse-nurse violence discourse. This critique revealed the feminist oppression narrative was evident among nurses. The double- whammy was that this violence-among nurses discourse was also revealed to be situated within other discourses identified as overarching patriarchally oppressive for nurses generally. Research revealed that nurses were also located within more dominant discourses, such as medicine, law and managerialism. Literature and research was critiqued that involved nurses in executive positions as a way to ascertain the gap in knowledge in relation to this role and that of middle-level nurses. Finally, the discourse of managerialism within health organisations was critiqued. This critique identified the economic agenda of managerialism negatively impacted upon nurses and other health professionals. In particular, managerialism was found to undermine one of nursing’s core values, that of care, both economically and professionally.

In my choice of what literature and research to incorporate and critique in this chapter I was mindful that by applying ethnography as both methodology and method there were no pre-predictable revelations. Thus, the notion of uncertainty of what data emerges from ethnography influenced my choice to critique a broad range of research and literature. My focus of critique was also influenced by my experience and accumulated assumptions as a nurse, manager, educator, academic and proactive professional nurse. Reiterating the comment by Roberts and Taylor (2002b:493) this literature and research review was a progressive process inclusive of that which initially affirmed the suitability
for me to progress my research plus ‘that which has come to light since the project began’.

Alternate critique could be made of the literature and research presented in this chapter. Further, different literature and research could have been included that may have demonstrated different perspectives to that which I have presented. However, from the critique presented in this chapter, there was an opportunity to suitably locate my research interest which may contribute to the body of local and international nursing knowledge.

In the next chapter, I detail the theoretical and philosophical principles and perspectives that informed my thesis. In linking this chapter with the next, I provide an overview of the research and literature critiqued in this chapter. The majority of the literature and research critiqued in this chapter indicated that the culture within which nurses practised supported: the continuing subjugation of nursing knowledge, less so of clinical expertise but distinctly that of nursing management expertise; destructive cultures of inter-professional nurse-nurse violence; disempowerment of nurse executives and the flow-on effect upon other nurses in the hierarchical system, including nurses in middle-level positions; oppressive marginalisation of nurses as a consequence of the health system’s managerialist business models, and the lack of financial valuing of nursing labour and of nursing’s care ethic. Scant research and literature was located that centred women’s voices. Emergent from this in-depth critique of what was being said around and about women nurses who practice in middle-level public hospital health systems was a confirmation of a gap in nursing knowledge within which my research could be located. Further, in chapter six, ‘The Voices of Middle-Level Women Nurses’, I refer to numerous additional research findings to support my discussion and analytic critique of the MLWNs’ lived experience.
Chapter 4.
Integrated Feminist Postmodern Methodology and Method
Introduction
This chapter details the investigation’s methodological context and methods. Savage (2000c:frame 2) drew from Ellen’s 1984 description of the meaning of methodology as ‘an articulated, theoretically informed approach to the production of data’. An integration of principles and selected concepts from critical social science, feminism and affirmative postmodernism informed my theoretical considerations for the investigation. Contemporary perspectives of ethnography further informed and were inherent within my approach to the investigation. The epistemological perspectives related to the nature of knowledge, truth, power, representation, the self and subjectivity/objectivity, and the meaning of difference (Carspecken 2003) were integral to the discussion of the methodology. These considerations were apparent from the inception of my interest of inquiry, the alignment of methodology and method, critique of the literature and through to analysis and presentation of the thesis. Thus, these considerations collectively aligned with the research question, aim and objectives.

There were a variety of theoretical perspectives that underpinned and permeated my ethnography. These theoretical perspectives were uncommonly applied in Australian nursing research practices. Therefore, I discuss each theoretical perspective separately and in detail in this chapter. However, like a picture, the whole comprises the close interconnectedness of individual components, each peculiar in its own way and together something unique and different again. This chapter develops the principal methodological influences for the ethnographic research investigation. In so doing, I deliberately include reference to many seminal theorists especially from the 1980s and 1990s whose perspectives continue to have relevance in contemporary critical social science and feminist theoretical thinking. Further, this demonstrates that publications are continuing over time in these theoretical perspectives. Where I believe comments and assertions by theorists and researchers is critical to the clarity of explanation or discussion I retain their words in the original. This
decision is twofold. Firstly, my interest is to acknowledge what they said. Secondly, I did not wish to risk distortion of meaning by paraphrasing.

Aligning to a number of critical theoretical perspectives, I have openly incorporated the various assumptions that I brought to the ethnography as integral to my discussions and critique in this chapter.

The chapter comprises five sections. The first section explains critical social science’s underpinning emancipatory principles. These principles are a preliminary introduction to this chapter as they framed many concepts of feminist postmodernism. The challenging and questioning approach of critical social science contrasted with the natural science research methodologies. Critical social science opened the way for social issues to be viewed differently and the emergent knowledge inextricably linked with social change.

The second section describes the multiplicity of feminist theoretical viewpoints. Of the numerous feminist principles, I found four feminist principles more pertinent to my investigation: women were oppressed within a patriarchal dominated culture; the feminist maxim: the personal was political; empowerment and transformation at an individual and collective level occurred within a reflective critical consciousness-raising environment; and women’s knowledge was valid. The feminists’ discourses of patriarchal power over women and the discourses of the historically biased and hierarchically constructed knowledge by the dominant white, middle-class, male that had marginalised woman’s knowledge were features implicit in my focus of attention.

In the third section of the chapter I integrate the key principles and perspectives of postmodernism and feminisms that influenced my perspective for the ethnography. Postmodernism also comprised a variety of multiple, competing and conflicting tensions that challenged notions of taken-for-granted assumptions of one truth and being. For postmodernists, meaning is not fixed and is partial (Lincoln & Guba 2000; Weedon 1999). Lather (1991a, b) and other feminist postmodernists challenged the traditional discourses of language,
power, knowledge, gender, identity, meaning and subjectivity. These postmodernist notions were influential to the way I viewed the investigation.

My research interest was to retain the strengths of feminist standpoint and second wave theoretical perspectives (Glass 2000; Hartsock 1997; Nicholson 1997) as well as applying postmodern thinking to the affirming and legitimating of individual women's differences, multiple subjectivities and realities (Code 1993; Glass & Davis 1998; Harding 1991, 1997; Heckman 1999; Lather 1991b). As such, I chose to apply an integrated feminist postmodern approach and used the framework proposed by Glass and Davis (1998, 2004) as appropriate for research of nursing cultural issues. Thus, also in the third section I provide an explanation of how this research approach had informed nursing knowledge and how it influenced my own research.

The fourth section develops the various aspects of Foucault's (1972 - 1994) concepts of the discourses of power/knowledge, technologies of the self, and governmentality as perspectives that have postmodern implications. I especially drew from Foucault's work because his concepts provided me with the opportunity to take the feminist agenda of my project with women nurses into a new space of understanding (Glass 2007; Holmes & Gastaldo 2002; Ogle 2004; Ogle & Glass 2006; Street 1992). In particular in this section I explore Foucault's (1980) notions of the interdependence between language, knowledge and power as a network of power relationships that produced and maintained the discursive construction of the day-to-day taken-for-granted culture within which we function.

The fifth section comprises two sub-sections. Firstly, I describe the philosophical methodological influences of ethnography that also framed the research. The second sub-section develops the underpinning principles and criteria that informed my methods for data collection and analysis that I applied to the ethnography.

Ethnography, as both methodology and method, allowed me to be in the reality setting of MLWNs, to experience with each MLWN and observe for myself what the culture was like for them. By immersing myself in the MLWNs' culture I
sought to establish a relationship of trusting reciprocity with each participant. This approach also fostered reflexive critical thinking for me to develop depth of understanding of their worldview of their working cultural context through the discourses of their practice. An ethnographic methodological approach which was overtly political and emancipatory in its intention (Taylor 2002b) was appropriate and influenced the theoretical constructs of the investigation. This approach also embraced the opportunity for me to locate and reveal my own subjectivity and biases. A discussion of traditional and critical ethnography is presented in section five which explains why ethnography was used to compliment the purpose (the ‘why’ factor) and the process (the ‘how’ factor) of the investigation.

Further, in section five, I discuss the doing of my ethnography in respect to a number of methodic considerations. One important research consideration related to the issue of validity of methodology and method. Therefore, I discuss various postmodern theorists’ approach in relation to qualitative, feminist, postmodern, and poststructural research validity. Of specific influence on my data analysis was my understanding and appropriated application of a selection of Patti Lather’s (1991b) poststructural research validity criteria for discourse analysis. Lather (1991b), as a seminal feminist poststructuralist/postmodern theorist and researcher, was especially pertinent to my appreciation of key features of feminist postmodernism. Of particular relevance to my ethnography were the works of Lather (199b) together with that of Foucault’s (1980) power/knowledge concepts and Glass and Davis’ (1998, 2004) integrated methodology and trifocal methods. These theoretical positions are discussed in this chapter. I then discuss other relevant aspects of ethnography as method, inclusive of: cultural context and meaning-making, reflexivity, intersubjectivity and reciprocity, storytelling and the role of the researcher, and triangulation of data management (participant observation and field notes, critical conversation, reflective journaling, and multiple member checks).

Throughout this chapter the literature that I drew upon was notably from the 1980s and 1990s as this was the era in which significant theoretical issues related to contemporary feminisms, postmodernisms and ethnography were being debated and especially within the nursing research context. The notions
and philosophical premises inherent within feminist postmodern ethnography continue to have contemporary relevance to the nursing research arena as was revealed from my literature search (Glass 2007; Ogle 2004; Walter 2003).

In section one, below, five sub-sections frame my discussion and critique of the key theoretical features which comprise critical social science. These were influential to my methodological considerations. The basis for feminist theories emerged from these underpinning theoretical perspectives.

**Section 1. Critical Social Science**

**Introduction to this section**

In this section, I develop an overview of the key features of critical social science as it contrasted with the natural sciences, within which emerged the models of objectivity, rationality, and scientific method (Harding 1991). These theoretical features demonstrated a paradigm shift in efforts to more appropriately understand the human condition. Introduced in this section are key critical social science terms which differentiate theoretical premises from those of modernist empirical positivism. Further, differentiation between critical social science and positivism is clarified in one sub-section. The notion of power as applied within critical social science is discussed and critiqued. My epistemological stance with critical social science is also clarified. Critical social science ideology underpinned many of the feminist perspectives and influenced the different directions emergent in postmodernist thinking.

In the first sub-section below I introduce the particular theoretical premises of critical social science.

**Relevant Theoretical Premises of Critical Social Science**

The history of the critical social sciences dates back to the 1930s. The principles and assertions made by critical theorists have not changed markedly since the emergence of the initial considerations. There was no one critical theory, rather particular premises which underpinned its thinking, a ‘cluster of themes inspired by the quest for freedom’ (Bonner 2002:4 emphasis in original). Critical researchers saw their work as a politically motivated initial step to rectify
social injustices at the local social level and within the research process (Kincheloe & McLaren 2005). The following descriptions show the principal premises comprising critical social science and how these aligned with my personal values. Many critical social science premises, like that of oppression, underpinned feminist perspectives which centred gender as the site of oppression.

Critical social science was one of many qualitative research methodologies. It differed from interpretive research styles, such as grounded theory, phenomenology, and classic ethnography in that it extended beyond the development of meaning and understanding of human affairs to that of a primary intention to create positive and liberating social change opportunities for its research participants (Bronner 2002; Lincoln & Guba 2000; Taylor 2002c). Critical theorists argued that in human affairs all facts, and thus, knowledge, were socially and historically constructed (Gibson 1986). For critical theorists, as described by Lincoln and Guba (2000:177), ‘knowledge is produced within the human consciousness; it is subjectively and intersubjectively located and intrinsically interconnected with knowledge gained from social critique’. As a secular endeavour, critical researchers have argued that culture needs to be viewed as a contested site within which is an ideological struggle over the production and diffusion of knowledge (Kincheloe & McLaren 2000). Of emancipatory critical social science researchers, Lather (1991c) and Gibson (1986) argued that they sought to gain understanding of the social world and to emancipate and liberate it. The context for critical social science was the perspective that human beings experience life in an unsatisfying, frustrating and oppressive way (Fay 1987). Critical social scientists’ views challenged the modernist Enlightenment ideals of progress and truth as illusionary (Bonner, 2002).

Various critical social science theorists provided different theoretical perspectives and explanations concerning the origins of oppression and how social change could be achieved. Kincheloe and McLaren (2000:279), for example, noted that the Frankfurt school theorists, Horkheimer, Adorno and Marcuse, did not develop ‘a unified approach to cultural criticism’. These early critical theorists, for example, ‘defied Marxist orthodoxy [capitalism framed
oppression] while deepening their belief that injustice and subjugation shape the lived world’ (Kincheloe & McClaren 2000:280). Fay (1987), along with Freire (1970), argued that for social change to occur, such as emancipation, a crisis must have had to exist of sufficient magnitude that people were forced to choose to function differently. However, Kincheloe and McLaren (2000:281) posed a reconceptualised perspective of contemporary critical theory, in that ‘it is concerned in particular with issues of power and justice and the ways that the economy, matters of race, class, and gender, ideologies, discourses, education, religion and other social institutions, and cultural dynamics interact to construct a social system’. Their perspective, influenced by ‘post-discourses’ broadened the view for the revealing of oppression, ‘critical enlightenment’ and self-emancipation (Kincheloe & McClaren 2000:281). In these different but aligned contexts, social change had political implications. Research within the critical genre was not perturbed by the label ‘political’ and prepared to integrate research with ‘emancipatory consciousness’ (Kincheloe & McLaren 2000:291 emphasis in original). The political concept of social change, at an individual level, such as, enlightenment, empowerment, transformation and emancipation were also integral to feminist research methodologies which inherently informed and underpinned my ethnography.

In the next sub-section plain English descriptions are presented of critical social science’s main terms.

**Critical Social Science Terminology**
The following plain English critical social science terms are presented in Table 23. ‘Critical Social Science Terminology’. The descriptions for each term are derived from my composite understandings for the critical social science literature.
Table 23. Critical Social Science Terminology

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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<tr>
<td>Oppression:</td>
<td>Domination by one or more persons, politics, rules, policies, or other factor that prevent the individual/group from experiencing freedom.</td>
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<tr>
<td>False consciousness:</td>
<td>Not knowing what you do not know; believing something is true when it really is not.</td>
</tr>
<tr>
<td>Enlightenment:</td>
<td>Insight about the cause of the oppression that is blocking the individual/group's freedom.</td>
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<tr>
<td>Empowerment:</td>
<td>Self-power that provides personal confidence to know how to overcome oppression.</td>
</tr>
<tr>
<td>Transformation:</td>
<td>The physical, psychological and/or spiritual ability to change oneself to cease being oppressed, or be able to remove the factors that cause the oppression.</td>
</tr>
<tr>
<td>Emancipation:</td>
<td>A state of liberation, experienced as a sense of freedom.</td>
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One particular definition of critical social science, that of the concept of empowerment could be drawn from an Indigenous Cross Cultural Cooperation Framework (WA Department of Education and Training 2005:14), ‘to be empowered is to know how to bring about positive social change/justice in one’s life as an Indigenous person’. Taking this definition more broadly to encompass all people, then, inherent in this definition was the respectful valuing of people from the perspective of the right to be human. This concept signified the principal stance within my investigation.

More recent considerations reconceptualised critical theory premises (Kincheloe & McLaren 2000, 2005) that accommodated the changing nature of social and informational conditions at the turn of the 20th century. Power, social injustice, economic determinism, class, race, gender, and sexuality continued to be sites for critical social science research that sought to understand the construction of an individual and society.

I framed my understanding of modernity using Fox’s (1993) reference, drawn from Giddens work of 1987, which refers to the period of Enlightenment, originating in the West in the eighteenth century with the emergence of secularized societies and scientific rationalism. Modernity was committed to scientific analysis that sought to establish how the world was to be known and encompassed humanism as an ideology, that was, ‘the centering of the human subject as the wellspring of knowledge and good’ (Fox 1993:7). Through rationality, modernity promised progress and liberation. Critical social scientists
challenged and criticised this instrumentalist rational ideology (Abercrombie, Hill, & Turner 2000) which, thereby, underpinned the concept of self-liberation – emancipation from oppression.

The next sub-section presents some theoretical differences between critical social science and the empirical-analytic genre of modernist positivism.

**Differences between Positivism and Critical Social Science**

Positivism, or the empirical-analytical genre (Lincoln & Guba 2000), had its focus of reality as external to human consciousness, that was ‘out there’ (Palmer 2002:99) and which sought to discover universal laws, based on objectivity and value neutrality, verifiability, measurement and manipulation of variables (Hammersley 1992). Lather (1991c) identified positivism as an intention to study society through the application of the scientific method. Harvey (1989:12) drew from Habermas (1983) to describe positivism, from the perspective of modernity, in which ‘the scientific domination of nature promised freedom from scarcity, want, and the arbitrariness of natural calamity.’ Further, Harvey (1989:12) noted that modernity sought to dispel the power associated with the irrationalities of superstition, myth and religion. Critical social scientists rejected these kinds of modernist promises.

Gibson (1986) clarified that unlike positivist natural science theory; critical theory was different because it embraced relativity and subjectivity as unavoidable, necessary and desirable characteristics. Critical social science was based upon an educative concept in which the role of knowledge was viewed as different from that of the instrumentalist model (Fay 1987). Critical social science sought to free people through the process of rational self-reflection (Fay 1987). Critical self-reflection, as an activity toward consciousness-raising and knowledge construction had no place within the objectivist model of positivist research.

Whereas positivism held instrumental rationality as a key feature, critical social science, Marxism and feminism sought to challenge it. Gibson (1986) and Fay (1987) noted that instrumental rationality split fact from value, means from ends, and method from purpose and aimed to exercise power, control and domination.
over humans and nature. The positivist manipulative approach risked dehumising by controlling human life: emotions, behaviour, motivation, economics, medicine and social aspects in general.

Fay (1987) and Freire’s (1970) critical social science concepts played an important role in my approach to the research settings with each participant. Fay (1987) drew from Freire’s (1970) critical social philosophy of an educational problem-based model that fostered enlightenment, transformation and emancipation through critical self-reflection by the oppressed. Critical social science research was not about acting on or for others, rather, it was about creating an open and trusting environment in which the people acted on their own behalf to liberate themselves (Fay 1987). Fay (1987) also situated his explanation that a critical theory could only be practical where the oppressed are not totally constrained by their dominators. One of my underpinning research assumptions was that middle-level women nurses who practice within the bureaucracy of public hospitals are oppressed, by their gender, profession and position. Thus, Freire’s (1970) ideology was pertinent to my research premises. Freire’s ideology was framed around the notions of the following:

To surmount the situation of oppression, people must first critically recognize its causes, so that through transforming action they can create a new situation, one which makes possible the pursuit of full humanity. . . . Although the situation of oppression is a dehumanized and dehumanizing totality affecting both the oppressors and those whom they oppress, it is the latter who must, from their stifled humanity, wage for both the struggle for a fuller humanity; the oppressor, who is himself [sic] dehumanized because he [sic] dehumanizes others, is unable to lead the struggle. (1970:29)

The concept of power within the frame of critical social science is discussed in the next sub-section.

Critical Social Science and Power
The development of a conceptual frame of reference for the term ‘power’ was integral to my research project. There was a plethora of literature on power in
relation to the practice of nursing management and leadership (Marquis & Huston 2003; Porter-O’Grady 1992; Quinn, Faerman, Thompson, & McGrath 1996; Senge, Kleiner, Roberts, Ross, & Smith 1994; Sullivan & Decker 1997; Swansburg 1996; Yoder-Wise 1999). However, the discourse of power within the theoretical perspectives of my research had particular meanings and intentions which emerge throughout this chapter. The notion of power, in respect to critical social science, was inextricably linked to the construction of the meanings of oppression, false consciousness, enlightenment, empowerment, transformation and emancipation.

From the perspective of my study, the language of the participants, my field notes and reflective journal and overall analyses were integral to the research matters. In the critical perspective the power of language, as one example, served to construct the meaning of the reality (Kincheloe & McLaren 2000). The discourse of linguistic power, further detailed in sections three and four of this chapter, had the capacity to serve as a form of control and manipulation. Kincheloe and McLaren defined linguistic discursive practices as:

A set of tacit rules that regulate what can and cannot be said, who can speak with the blessing of authority and who must listen, whose social constructions are valid and whose are erroneous and unimportant. (2000:284)

Fay’s (1987) explanation of power and powerlessness was one of a dyadic consensual relationship between the leader/s and followers. He referred to the crucial role between a leader’s self-knowledge and the construction of power (Fay 1987). This notion implied that oppression could be overcome by the oppressed by actively withdrawing their ‘allegiance’ from the oppressors (Fay 1987:122). On the other hand, those who accepted to be manipulated gave consent to be manipulated, and unwittingly may not have realised that their interests were also deliberately ignored by those who dominated them (Fay 1987). This construction and application of power, in my view, had a strong resemblance to that which existed in government bureaucracies, like public hospitals, where legitimacy of power was a taken-for-granted downwardly hierarchical system and was rarely contested. In respect to the organisational
order of power within a hospital, using Fay's (1987) concept, subtle as well as overt manipulation was used whereby subordinates' identity, self-understandings and place within the organisation were socially, systematically and formally manipulated. I considered these notions of tacit acceptance and hegemonic discourse of power status within a bureaucracy may be a taken-for-granted assumption among the MLWNs.

However, Fay (1987) also considered power as an enabling feature; whereby individuals or groups can resolve to use their power to resist being dominated. Empowerment in this way interested me in respect to potential strategies used by MLWNs to counter-resist their subordinated status. This aspect of my inquiry was further influenced by Freire’s (1970) descriptions of oppression and liberation as noted earlier in this section and further discussed below.

As my investigation incorporated an emancipatory interest, I was further drawn to Freire’s (1970) description of oppression in which he asserted that oppressed people live in a culture of silence, where they are not aware of their submissiveness nor of the power they have to change their situation. Fay (1987) supported Freire’s (1970) notion that those who have unwittingly adapted to living with subjugation accepted it and internalised the values of the oppressor and strove to be like their oppressors. The internalisation of repressive values may, in turn, have increased their resistance to create change and become free. The status quo was further maintained by the oppressors who sought to retain their dominance. These critical social science notions made significant impressions upon me within the context of women and that of nurses, noted historically as oppressed groups (Chinn & Wheeler 1985; Glass 2007, 2003a, b, 1997; Harding 1997; Hartsock 1997; Heckman 1999; bell hooks 2000a, b; Horsfall 1996; Lather 2001a, b, c; Weedon 1999). I was interested to understand whether these notions were evident among the MLWNs and if so how did they manage it.

The particular notions of power I applied to the ethnography are elaborated further in subsequent sections in respect to feminism and integrated feminist postmodernism. Some of my assumptions and values related to the various
underpinning principles of critical social theory are discussed below in the next sub-section.

**Ideal versus Partiality – My Stance**

My personal beliefs rejected the totalising premises of critical social science as being able to solve the world’s social problems with one truth, one theory, because it inadequately accounted for individual differences or experiences. For me, there was too much of a pessimistic and oppressive world-view that people needed to be saved from their own ignorance (Fay 1987). Hammersley (1992) confirmed for me the inappropriateness of pursuing a full critical social science approach based upon his criticism of its ideology. One of his (Hammersley 1992:106) criticisms focused on critical social science’s beliefs of the historical progression toward the conscious recognition of human ideals and where the pursuit of truth involved ‘changing future reality in order to bring it more completely into line with that truth’. This kind of ideology for me was unsustainable as it made claims that these theorists knew what constituted the essential ideals that constituted human nature. However, critical science methodology, especially that informed by Habermas (Fontana 2004:frame 3), I acknowledge, has had an important role and presence in nursing research. On a partial and contextual basis, however, critical social science premises had relevance to my study. The relevance related to the inclusion in my focus and analysis of the participants’ narratives of their perceptions of how free and liberated they felt to achieve their work-related goals. Of further interest, to reveal what strategies they applied to overcome or resist oppression as they experienced it. In disclosing their experiences I assumed the MLWNs’ ‘narratives represent a primary embodiment of [their] understanding of the world, of experience, and ultimately [them]selves: the typical way in which experience is framed and schematized and orderly worlds constructed’ (Rapport 2000:75).

**Summary of Section 1. Critical Social Science**

The frame of reference for critical social science that particularly influenced me encompassed the notions of oppression and the potential ability for people to be liberated to have a more free and satisfying life. The emancipatory agenda
of criticalist thinking embodied much of my educational philosophy and practices and thus was inherently relevant for my investigation. The underpinning aim of critical social theories was a more preferred alternative for me than the positivist’s instrumental rationalism for the human condition which I clarify at the end of the next section. However, I found the potential totalising aspects of critical social science ideology unsustainable at the local personal level.

In section two that follows, I detail the principal features that comprised the multiplicity of feminist epistemologies and elucidate those perspectives which informed my ethnography. I also clarify the constraints that I understand between modernist Enlightenment epistemology, critical social science and feminism and locate these within a postmodern critique.

**Section 2. Feminist Principles that Informed the Ethnography**

**Introduction to this section**

In this section of the chapter, I establish the key feminist principles that especially influenced my perspectives for the ethnography. My fundamental concern for women’s persistent subservient position in our Australian society, and more specifically, that of women nurses’ inferior position in the health care system, located my epistemological research interest within a feminist genre. Bashford’s (1997) and Curthoy’s (1988) portrayal of Australian women in society provided clarity for me that Australian women’s issues have continued to be marginalised and depoliticized. One of my key assumptions, from personal and professional experience, was that nurses, individually and as a unique collective social group, were oppressed and restricted in their means to be heard by other health professionals and by many of their peers. Cheek and Rudge (1995) and many Australian nursing scholars (Chiarella 2002; Glass 2007; Glass & Davis 2004; Horsfall 1996; Lawler 1991; Lewis 2001; Ogle 2004) argued that not only was nursing an undervalued occupation but also that nurses have been historically subjugated because it was predominantly female in gender.
Nursing was subordinated to the patriarchal dominant discourse of medicine which was taken-for-granted and as a consequence of their subjugation nurses' knowledge was poorly valued (Chiarella 2002). Discursive frameworks, like those of medicine and health ‘enable and constrain the production of knowledge in that they allow for certain ways of thinking about reality whilst excluding others’ (Cheek 2000:23). Such dominating discourses determined who had authority to speak. Knowing that these studied observations of nursing aligned with my understanding confirmed for me that feminist principles, primarily those of second-wave feminist theories of patriarchal oppression, were integral to every aspect of my research project. Also integral to my research interest was that feminism recognised ‘women's lived experiences as legitimate sources of knowledge’ (Campbell & Wasco 2000:frame 1) and which took into account difference, thus not essentialising or universalising those experiences (Cosgrove & McHugh 2000). Lather’s description of feminism summed up my epistemological and ontological stance:

Through the questions it poses and the absences it locates, feminism argues the centrality of gender in the shaping of our consciousness, skills and institutions as well as in the distribution of power and privilege. The central premise of feminism is that gender is a basic organizing principle of all known societies and that, along with race, class and the sheer specificity of historical circumstances it profoundly shapes/mediates the concrete conditions of our lives. (1987:25)

The historical emergence of multiple feminist epistemological perspectives is discussed in the next sub-section. It was selected feminist perspectives that informed my ethnography.

**Feminisms’ Emergence**

The feminist project, since its identified emergence in the 1700s focused, in varying ways, on the oppression of women within society. Most contemporary feminist writers spoke of three waves of the feminist movement (Glass 2000). First-wave feminism, the early feminist intent, was chronologically situated in the late 1800s into the early 1900s of which its political focus was social
equality for women – especially voting rights and rights to education (Chinn & Wheeler 1985; Glass 2000).

Second-wave feminist perspectives (Bond & Mulvey 2000) arose from critical social science, in the 1960s. Its intent was to take further first-wave feminist political actions. More directly, however, it aimed to overcome women’s oppression, leading to a more satisfying life through enlightenment, empowerment, emancipation, and transformation. In the Western world, the era of the 1960s was a time of dramatic social and sexual revolution. For feminists this perspective incorporated first-wave feminist rights and other social equity issues such as ‘equal opportunity; work; education; abortion; sexuality; domestic violence; incest; rape; and pornography’ (Glass 2000:360). The feminist notion of the personal is political arose from second-wave feminist action. Within this context feminists fought issues associated with male domination over women in personal, economic and institutional areas of life (Glass 2000). Differing perspectives emerged from the second-wave, such as Marxist, liberal, radical, standpoint, empiricist, and lesbian political feminist positions (Campbell & Wasco 2000; Glass 2000).

Since the 1980s third-wave feminist interests emerged (Glass 2000). Earlier feminist pursuits sought to create a one-size-fits-all metatheoretical stance for women. Third-wave feminists were skeptical and resistant to the risks associated for women who sought universalising truths or actions for all women. The third-wave era focused particularly on individual women’s self-determining issues and their experiences within society. These feminists were concerned to ‘search on epistemological and ontological levels for more plausible ways of understanding the experiences of all women by validating differences amongst women, and simultaneously recognising the importance of unity concerning oppressive states’ (Glass 2000:363 emphasis in original). It was the points of fragmentation inherent in third-wave perspectives that Glass (2000) noted provided opportunities to expose deeper understandings of women’s oppression but within the context that not all women were oppressed equally or in all aspects of their lives. Third-wave feminists actively endeavoured to maintain the momentum for social and political change that benefited all women. It also focused upon consideration of differences amongst women.
I needed to comfortably locate my assumptions of nursing oppression and create the most appropriate focus for my approach to the study. To do this, it was important that I deeply understood the multiplicities of feminist thoughts, insights, principles, theories and methodologies and its evolutionary processes.

The three historically distinct waves of feminist theory were explained by Nel Glass (2000) in her publication, *Speaking feminisms and nursing*. This work contributed significantly to my understanding the particular perspectives which most aligned with my values and experiences. Gender imbalances, women’s oppression and political action that improved women’s way in the world were noted as common threads throughout the feminist movement’s history, theoretical perspectives and research methodologies (Glass 2000). The three major feminist premises explored by Glass included:

1. Women are oppressed within patriarchal societies.
2. The personal is political; that is, there is a direct relationship between social change and political action.
3. Consciousness-raising processes are fundamental to an understanding of women’s reality. (2000:355)

Glass (2000) noted, of her first premise, that it was important to understand how individual women’s lives were manifestly oppressed by patriarchy. Glass (2000) and Flax (1999) agreed that this understanding took precedence over other forms of women’s oppression, such as class, race, sexuality, and spiritual beliefs. Of the second premise, Glass (2000) noted that there was an interwoven connection between personal and public domains. This was manifest by the interconnectedness of women’s experiences and the impact of politics, in general, upon women. For Glass (2000) consciousness-raising, her third premise meant that women’s individual voices could be heard and their reality validated in the process of sharing their stories. This kind of dialogic knowledge creation was similar to what Jan Horsfall (1996) identified as a key feminist principle in respect to theory and research development. Both Glass (2000) and Horsfall (1996) acknowledged the value of starting critique, research or political action from the point of women’s experiences.
Glass’ (2000) three feminist premises were somewhat of a blend from first-wave, second-wave and contemporary postmodern feminist perspectives. Glass (2000) further asserted the importance of the proliferation of the different theoretical positions that now constituted a multiplicity of feminist perspectives. She claimed that these ‘provide a framework to conceptualise the various underlying explanations of women’s historical and current oppression’ (Glass 2000:358). Kemp and Squires’ (1997) publication, *Feminisms*, attested to the diversity and dynamism within feminist pursuits. They claimed that ‘there is no unchanging feminist orthodoxy, no settled feminist conventions, no static feminist analyses’ (Kemp & Squires 1997:12).

Further, with permission, I include Nel Glass’ (2000:360-362) three tables of her Focal Points of Feminism that showed the emergence of the differing concepts inherent within feminist thought: Table 24. ‘Focal points of first wave feminism’; Table 25. ‘Focal points of second wave feminism’; Table 25.1. ‘Types of second-wave feminists and their associated main issues’; and Table 26. ‘Focal points of third wave feminism’.

<table>
<thead>
<tr>
<th>Table 24. Focal points of first wave feminism (late 1800/1900s)</th>
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<tbody>
<tr>
<td>- The lack of material benefits and production for women.</td>
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<tr>
<td>- The right to vote.</td>
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<td>- The viewing of women as objects.</td>
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<tr>
<td>- Women as victims of mistaken social knowledge (eg women should not be ‘thinking’ people and have a voice).</td>
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<td>- Women wanting to be self-determining, enlightened and sexually liberated.</td>
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<tr>
<th>Table 25. Focal points of second wave feminism (1960/1970s)</th>
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<tr>
<td>- Challenges to patriarchy by focusing on issue politics.</td>
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<tr>
<td>- Strong belief in the ‘personal is political’.</td>
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<tr>
<td>- Putting beliefs into political action.</td>
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<tr>
<td>- Consciousness-raising groups.</td>
</tr>
<tr>
<td>- The belief that patriarchal power is visible and also invisible.</td>
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<tr>
<th>Table 25.1. Types of second-wave feminists and their associated main issues</th>
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<tr>
<td>- Liberal - equality</td>
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<tr>
<td>- Marxist - capitalism/class</td>
</tr>
<tr>
<td>- Radical - transforming patriarchy/male power-over interactions</td>
</tr>
<tr>
<td>- Lesbian - recognition of sexual orientation and rejection of male desire</td>
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Table 26. Focal points of third wave feminism. (1990 -)

- As a result of the gains of the second wave such as consciousness raising, social change and political action women’s oppression is less overwhelming than feminists have previously argued.
- Women are subjects as well as objects and can be active participants in their communities and agents for change.
- Individual women’s experiences are unique and different to each other.
- Uniqueness and difference cut across and are existent within race, class, sexuality and spirituality.

Taking the feminist perspectives as explored and discussed above by Glass (2000) and other feminist theorists I construct an explanation of my feminist context in the following sub-section.

My Feminist Context
Of the theoretical notions from first and second wave feminisms it was second-wave radical feminist principles which provided me with a composite of personal, philosophical and political perspectives with which to understand the patriarchal systems that influenced women’s realities (Chinn & Wheeler 1985). Radical feminism centred gender oppression and called for social and institutional restructuring to rectify the inequity and marginalisation of women (Campbell & Wasco 2000). I found radical feminist principles applicable to my view of women’s oppression and especially in its context with women nurses. I concurred with Emden’s (1995) own nursing experience and subsequent critique about women being an add-on to the historically masculine dominated Western philosophies. Emden’s (1995:35) replacement of ‘feminism’ with ‘nursing’ also fitted very comfortably with me.

Second-wave feminist theories emerged at the same time as the 1960s sexual revolution. It was the more overarching concern of women’s oppression in which men’s power prevented women from being ‘fully self-determining human beings’ (Glass 2000:362) that made a personal and professional connection for me. The words of Davis (1998:52) also deeply resonated with me in that ‘the notion of separating the personal and professional, or my knowing and being, was something I no longer accepted as valid’. My feminist advocacy stance (bell hooks 1997) confirmed for me that my research efforts to support and
encourage nurses to value what they knew could be framed within feminist epistemology (Reinharz 1992).

Of feminist theory, Code’s statement was also influential in that:

Feminists have to understand the ‘the epistemological project’ to be in a position to see its androcentricism and to comprehend the political consequences of its hegemony. (1991:314 emphasis in original)

Reinharz (1992:7) quoted Australian scholar Dale Spender’s feminist definition:

At the core of feminist ideas is the crucial insight that there is no one truth, no one authority, no one objective method which leads to the production of pure knowledge. This insight is applicable to feminist knowledge as it is to patriarchal knowledge, but there is a significant difference between the two: feminist knowledge is based on the premise that the experience of all human beings is valid and must not be excluded from our understandings, whereas patriarchal knowledge is based on the premise that the experience of only half the human population needs to be taken into account and the resulting version can be imposed on the other hand. This is why patriarchal knowledge and the methods of producing it are a fundamental part of women’s oppression, and why patriarchal knowledge must be challenged – and overruled. (1985)

The female gender was centred in feminist perspectives. Women’s gender had been subjugated and marginalised by historical male gendered ideology. Contextualised within second wave feminism these notions were critically important epistemological constructs as the lens through which my feminist research was focused. These notions are discussed in the next sub-section.

**Feminist Theory and its Focus on Women’s Gender**

Glass’ (2000) practice-based feminist theory focused upon validating and giving voice to women as women. Feminist thought had women’s gender and politics as central features (Kemp & Squires 1997; Lather 1991b; Stanley & Wise
For Glass (2000) and Flax (1999), patriarchy was understood as oppression of women which was socially constructed and the system in which men wield more power than women because men have established what was valued in society. Kemp and Squires (1997:12 emphasis in original) in their introduction to their text *Feminisms* noted that ‘the categories of “man” and “woman” currently remain constitutive of our identities, and in hierarchically inscribed ways’.

Hartsock’s (1997) standpoint feminist theoretical perspectives, influenced by Marxism, alerted me to her feminist notions of a person’s essence. Showalter (1997) and bell hooks (1997) brought my attention to the problematics of racism and non-differentiated diversity associated with essentialism of the universal female subject in early feminist theory. Chodorow’s (1997) psychoanalytical feminist theory deliberately intended to unsettle the theoretical realms of psychological anthropology’s focus on sex and gender. Whitbeck (1999) critiqued the dominance of the male in sex difference Western philosophy and which based female sex difference as the fantasies of men. Harding’s (1997:163 emphasis in original) clarification, of significance for my research project, was that ‘it is “women’s experiences” *in the plural* which provide the new resources for research’. These emergent feminist perspectives, and others, led to the multiplicity of feminisms and, thus, multiple feminist epistemological possibilities.

Falk Rafael (1996) examined the notion of Foucauldian dialectic to reveal the contradictory concepts of power and caring. She noted that the traditional masculine characteristics were congruent with power contrasted with those characteristics of femininity which were attributed to caring. These concepts helped frame my analytic lens of the MLWNs in feminist ways rather than simply as subordinates to doctors and hospital administrators. I sought to understand the MLWNs’ experiences within their wider hegemonic masculinist social context.

In the social world of the WA public hospitals the dominant culture was patriarchal and hierarchically structured as exemplified through both authority and power-over relationships. For example, statistics from the *Women’s Report*
Card (Department of Community Development, Government of WA 2004) identified that only 27% of women held corporate executive public sector positions. The report also identified that executive positions allowed for leadership and decision making and was an important measure against the government’s Equal Opportunity laws. This seemed an oxymoron statement, whereby the commitment to equal opportunity did not stack up equitably against the paltry statistics for women! The high evidence of gender imbalance was not new. For example, Labor Members’ of Parliament in WA criticised the Premier for ignoring the party’s democratic processes in his promotion of ‘favourites’. He was also criticised because ‘it was becoming increasingly clear that there was no room for women in prominent positions within the government, citing the fact that five men were appointed to Cabinet during the last reshuffle’ (Strutt 2005 October 20:1). Of significance was the appointment of Julia Gillard, the first woman to be a deputy leader in a major political party and who was sworn in as a consequence of Labor’s federal election win in late 2007. The outgoing federal Liberal party reshuffle also included several prominent women politicians into the new Opposition party.

Further and of equal relevance to my investigation, in Australia, our literature and social conversation ascribed the gender of doctors and administrators (and of women in executive positions) as male, and that of nurses, as the subordinated group, as female. Biological sex differences was of equal significance to my interests as that of gender characteristics as a social relation and socially constructed concept (Whitbeck 1999; Butler 1997; Flax 1990; Lloyd 1989).

Florence Nightingale structured nursing as an organised workforce directed by doctors and in which the care value was subsumed under the emergent scientific medical paradigm (Brennan 2005; Falk Rafael 1996; McInerney 1998; Widerquist 2000). Since then, women have been the principal constituents within nursing, with the number of men slowly increasing (AIHW 2004). The status within WA public hospitals, at the time of the ethnography, was that women predominated in nursing (including executive nursing positions) and men predominated in other executive positions. The feminist stance of patriarchal oppression was still relevant for the purposes of my investigation.
The attributed gender social roles of staff with whom the MLWNs related was my research focus of attention and not specifically that of their gender identity or biological sex. Of gender difference Flax noted:

We as well as men internalize the dominant gender’s conception of masculinity and femininity. Unless we see gender as a social relation rather than as an opposition of inherently different beings, we will not be able to identify the varieties and limitations of different women’s (or men’s) powers and oppression within particular societies. (1990:54)

Lugones and Spelman (1999) noted that feminist theory focused on how women attributed meaning to their experience as women. This focus was more specifically clarified by Flax (1990:40) in her reference to a principal feminist research goal which was to ‘analyze gender relations: how gender relations are constituted and experienced, and how we think or, equally important, do not think about them’.

Women’s knowledge in various areas and throughout history has been excluded. Extending this notion in sociology Sandra Harding (1987) posed, in her discourse of feminist epistemologies, that sociologists have excluded women’s possibility to be knowers and knowledge producers. In the area of physics and scientific knowledge Margaret Wertheim (1997) pointed out the extreme gender bias against women being permitted or acknowledged as knowledge creators. She supported the historical context of the exclusive androcentric scientific world which had denied women’s participation since Ancient Greek times. Kelly-Gadol (1987), and Campbell and Wasco (2000) further contended that women’s knowledge, through historical accounts, had been socially constructed by men.

Throughout the past thirty years feminist scholars and researchers (Campbell & Wasco 2000; Code 1991; Harding 1987,1997; Luke & Gore 1992; Reinharz 1992; Stanley & Wise 1993) have focused upon projects investigating how women know what they know. The intention of such research was upon validating the ‘possibility of women as producers of legitimate knowledges’ (Horsfall 1996:343). In the text Feminisms and qualitative research at and into...
the millennium Olesen (2000) showed that since the 1960s feminist research had expanded and became increasingly complex with the emergence of a multiplicity of ‘knowledges’ as a leading feature. Of feminist research, Reinharz asserted:

Making the invisible visible, bringing the margin to the center, rendering the trivial important, putting the spotlight on women as competent actors, understanding women as subjects in their own right rather than objects for men – all continue to be elements of feminist research. (1992:248)

Jean Watson drew attention to the postmodern challenge of whether nurses would:

Take advantage of the fact of change, chaos, and ambiguity, deconstruction, and so on, and participate in reconstructing, cocreating a novel and moral direction for knowledge and practice, leading us forward, toward an ever-evolving humanity of possibilities. (1995:63)

Summary of Section 2. Feminist Principles and Insights that Created Space for the Ethnography

Prior to commencing the ethnography it was critical for me to comprehensively understand the underlying theoretical principles of feminist emancipatory research. Glass and Davis (1998) highlighted a fundamental premise of nursing research informed by feminism. They contended that the researcher needed to appreciate the possibilities and limitations for research participants to potentially be empowered and/or transformed as a consequence of the research. In my discussion thus far I have drawn from various seminal and contemporary feminist insights and stances. For the ethnography I selected various feminist insights over others whilst retaining the integrity of my interest to support the de-silencing and, thus, the possibility for empowerment of the women in the study. From my ontological perspective, deeply and broadly understanding the different feminist perspectives provided me with a frame of reference to view the patriarchally invasive and socially embedded nature of women’s oppression. Further, this perspective provided a stance upon which to valorise women’s lives and experiences as sources and sites of legitimate knowledge.
Creating space for emancipatory transformative possibilities and supporting the legitimation of women’s knowledge within the frame of traditionalist modernist epistemology was not my problem alone. It was the principal barrier confronting all feminists. It was also a feature of resistance and challenge by the more recent third wave feminists who had embraced postmodernism (Glass 2000). The move of feminist epistemology, which aligned with my own research interest, toward postmodernism was also taken up by Kemp and Squires in their comment that:

The extent to which feminist theories, of many different types, have subjected enlightenment rationality to critique, and the searching way in which feminists have questioned the attempts within their own ranks to develop a different epistemological voice, leads some to suggest that feminism might, in these senses at least, be an intrinsically postmodern discourse. (1997:145)

Each of the feminist scholars and researchers from whom I have drawn my discussion to this point, acknowledged a similar comment made by Harding (1990). Harding (1990:90) contended that ‘feminists have developed justificatory strategies that value feminist perspectives as resources for organizing to end male domination’. Further, Harding (1990:90) clearly articulated that feminists ‘struggle to create space for feminist voices within worlds – academic, intellectual, social, economic, state policy, judicial practice, health care – that continually try to squeeze them out, isolate them, and co-opt them’.

At the time of the ethnography, the WA public hospital system and organisational structure was typically bureaucratic imbued with limited and constrained opportunities for change within the hierarchy, at any level. It was a seriously long-standing ailing system, noted by health care being a prominent and critical governmental political controversial issue, as was the poor salary status of WA nurses (Miraudo 2004:November 28; Miraudo 2001:April 29; Drummond & O’Leary 2005:September 21; Pennells 2003:January 4; 2001: Watts 2001:February 24; Clery 2001:December 3). The endemic resistance to change within bureaucracies, like that of public hospitals, in my view was a
nurtured patriarchal resistance by those in authority and was not a site openly transparent or favourable for nursing transformation. Feminist principles which centred women’s gender and women’s local political activism created space for my research inquiry. Through a critically reflective and intersubjective research approach there was potential to unmask aspects of domination upon the social reality of nursing by institutionalised power systems and relations (Thompson, 1987, in Glass, 1998) and effect change at the local research participant level.

In the following sub-section, as part of my summary of sections one and two of this chapter, I clarify what aspects I rejected as epistemological constraints of critical social science and feminist epistemology.

**Modernist Constraints Inherent in Critical Social Science and Feminism**

Modernist feminist epistemologies, such as feminist empiricism and standpoint theories, were constrained by scientific positivist essentialising theory development in that these aimed to speak for all women (Baber & Allen 1992). Positivist research collected data from participants, refined it down to categories or statistics, as determined by the researcher who self-proclaimed to be an objective knower (Taylor 2002c). Positivist methods have undoubtedly benefited many aspects of feminist issues. It did not fit totally, however, with my ontology. I did not believe people and their lives could be reduced to chunkable essential elements, or be constituted as abstract notions created in the minds of people who positioned themselves as the authority of the process and outcome. Modernist epistemologies, in my view, extinguished the wholism of the person; ideas and concepts that could not be reconstituted in any realistic and understandable form. Difference, as a feature of being human was also not taken into account. Fraser and Nicholson (1990:27) asserted of modernist feminist theories, ‘they tacitly presuppose some commonly held but unwarranted and essentialist assumptions about the nature of human beings and the conditions for social life’. One positive feature of feminism, as a modernist paradigm, was that it challenged the ‘homocentricity of Enlightenment knowledge and even the status of “man”’ (Heckman 1990:2 emphasis in original).
The basic premises of critical social sciences and feminisms were modernist paradigms which focused on dichotomies, such as rational/irrational, objective/subjective, knower/known, in which the white Western ‘man’ epitomised all humanity, headed the hierarchy and subjugated woman to an inferior position. There were other features associated with the Enlightenment project with which I did not agree. Cheek (2000: chapter 1 notes:15), for example, drew upon a quotation from Hampson (1999) to explain that a key feature of the Enlightenment was the belief that:

All aspects of nature, including human nature and society, are regulated by universal natural laws that can be uncovered through the application of ‘scientific methods of observation and deduction’. (Hampson 1999:195)

From a postmodern perspective, Flax (1997:172) itemised the doubts she held of the Enlightenment as paraphrased and listed in Table 27. ‘Postmodern Doubts about the Enlightenment (Flax 1990:41)’. This information collectively and succinctly clarified for me that my ontological and epistemological alliance was skeptical of some of the features of the Enlightenment and which led me to pursue an integration of feminist principles with those of affirmative postmodernism.
Table 27. Postmodernist Doubts about the Enlightenment (Flax 1990:41).

<table>
<thead>
<tr>
<th>Postmodernist Doubts about the Enlightenment (Flax 1990:41)</th>
</tr>
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<tbody>
<tr>
<td>- The existence of a stable, coherent self. Distinctive properties of this Enlightenment self include a form of reason capable of privileged insight into its own processes and into the ‘law of nature.’</td>
</tr>
<tr>
<td>- Reason and its ‘science’ – philosophy – can provide an objective, reliable, and universal foundations for knowledge.</td>
</tr>
<tr>
<td>- The knowledge acquired from the right use of reason will be ‘true’ – for example, such knowledge will represent something real and unchanging (universal) about our minds and the structure of the natural world.</td>
</tr>
<tr>
<td>- Reason itself has transcendental and universal qualities. It exists independently of the self’s contingent existence (e.g., bodily, historical, and social experiences do not affect reason’s structure or its capacity to produce atemporal knowledge).</td>
</tr>
<tr>
<td>- There are complex connections between reason, autonomy, and freedom. All claims to truth and rightful authority are to be submitted to the tribunal of reason. Freedom consists of obedience to laws that conform to the necessary results of the right use of reason. The rules that are right for me as a rational being will necessarily be right for all other such beings. In obeying such laws, I am obeying my own best transhistorical part (reason) and hence am exercising my own autonomy and ratifying my existence as a free being. In such acts, I escape a determined or merely contingent existence.</td>
</tr>
<tr>
<td>- By grounding claims to authority in reason, the conflicts between truth, knowledge, and power can be overcome. Truth can serve power without distortion; in turn, by utilizing knowledge in the service of power, both freedom and progress will be assured. Knowledge can be both neutral (e.g., grounded in universal reason, not particularly ‘interests’) and also socially beneficial.</td>
</tr>
<tr>
<td>- Science, as the exemplar of the right use of reason, is also the paradigm for all true knowledge. Science is neutral in its methods and contents but socially beneficial in its results. Through its process of discovery we can utilize the laws of nature for the benefit of society. However, in order for science to progress, scientists must be free to follow the rules of reason rather than pander to the interests arising from outside rational discourse.</td>
</tr>
<tr>
<td>- Language is in some sense transparent. Just as the right use of reason can result in knowledge that represents the real, so, too, language is merely the medium in and through which such representation occurs. There is a correspondence between word and thing (as between a correct truth claim and the real). Objects are not linguistically (or socially) constructed; they are merely made present to consciousness by naming and the right use of language.</td>
</tr>
</tbody>
</table>

The discussion from section one of critical social science and section two of key features of the plurality of feminist principles and epistemology were important lead-in critiques to the next section. In section three further feminist perspectives are discussed as these emerged from the literature to align with the multiplicities of postmodern thinking. As an unstructured methodological paradigm, postmodernism is explored in detail in this section with particular inclusion of perspectives that aligned with my ontology and values. As an integrated feminist postmodernism methodology informed the ethnography this
section has teased out various concepts and perspectives of particular relevance to demonstrate another lens through which I viewed the ethnography.

There are eight sub-sections to the next section, several of these focus discussion and critique around the notion of difference. Difference was a principal postmodern concept, from Heckman's (1999) explanation of feminist postmodernism. In the final sub-section I develop in detail Glass and Davis' (1998, 2004) integrated feminist postmodern model that they asserted as applicable for nursing research and discuss why this methodology suited my ethnographic aim and research objectives.

Section 3. Integrated Feminist Postmodernism

Introduction – Difference as an Encompassing Postmodern Concept
This section of the chapter draws from a number of postmodernist and postmodern feminist scholars. My aim is to articulate particular postmodern perspectives as well as integrating these with components of feminist thought that aligned with both my ontological and epistemological interests. Georges (2003:45) proposed that the alignment of feminism with postmodernism was newly emerging in nursing scholarship as an ‘intertext’, something new between these two discourses.

It was in postmodern thought I found I could retain the uniqueness and individuality of each woman participant’s experiences and narratives of her lived reality. I could also incorporate a collective perspective of them whilst integrating my feminist emancipatory and transformative interests into the investigation. Along with Glass (1998, 2000) and Glass and Davis’ (1998, 2004) model for an integrated feminist postmodern nursing research methodology, McRobbie (1993) also drew my attention to the notion that modernism and postmodernism were not binary opposites. Rather the value of a postmodernist interrogation ‘clearly shows how [dominant] arguments bury opposition’ (McRobbie 1993:132). The internationally acclaimed French feminists, Luce Irigaray, Hélène Cixous and Julia Kristeva, were early adopters of integrating postmodernist thoughts within feminist critiques and research because of the
Postmodern connection with disrupting the status quo and dominant discourses (Huntington & Gilmour 2001).

Postmodernism also supported the inclusion of the researcher’s own cognitive qualities as noted by Roberts and Taylor (2002c). Focusing on Rosenau’s (1992) ideas, affirmative postmodernist research was increasingly influencing a shift away from the natural science scientific method towards methods that were guided by researcher ‘feelings, empathy, emotion, intuition, subjective judgment, imagination, creativity and play’ (Roberts & Taylor 2002c:18).

Postmodernism, from Baber and Allen’s (1992:10) perspective ‘embraces the ambivalence, paradox, and heterogeneity that is generated and rejects reductionism and naïve dualisms’. Further, as a powerful tool to explore women’s experiences, postmodernism persuasively critiques essentialism which blends with feminism’s political social analysis and activism (Baber & Allen 1992). Further, Cole (1995:196) affirmed that researchers within postmodernism located politics at the level of the text, that was language. As such, postmodernism sought to subvert taken-for-granted cultural meanings (Cole 1995). This culturally subversive construct clearly aligned with feminisms’ political intention that benefited women.

Of particular clarification of postmodernists’ perspectives, Rosenau’s was pertinent:

[Post-modernists] offer indeterminacy rather than determinism, diversity rather than unity, difference rather than synthesis, complexity rather than simplification. They look to the unique rather than to the general, to intertextual relations rather than causality, and to the unrepeatable rather than the re-occuring, the habitual, or the routine. (1992:8)

bell hooks (1997), a highly regarded African-American international feminist scholar, confronted the dominance of white feminist theory that opened up the falsity of women being commonly oppressed. The issue of difference between women was made markedly apparent by bell hooks’ (1997) critiques which could no longer be ignored by feminist theorists and researchers. Chris Weedon
(1999), a feminist poststructuralist, extensively explored the complex issues of difference within an historical account of feminist thought and politics. Weedon (1999) highlighted the theoretical and political need for feminists to view difference without constraints but in liberating perspectives. Weedon (1999) further described the emergent postmodernism of the late twentieth-century as a paradigm shift. The ‘modernist epistemologies’ were disrupted and the paradigm was ‘characterized by the movement from the universal to the particular, from Truth to ‘truths’ and this was problematic for modern feminists (Weedon 1999:23 emphasis in original). Now, postmodernism, referred to as a ‘paradigm of differences’ dislocated the foundation for a truth because ‘truth is plural and relative, historical and particular’ (Weedon 1999:24). This change, as Weedon (1999) argued, required feminists to rethink how feminist knowledge and politics could be foregrounded and retain a basis for meaning within a postmodernist perspective where the concept of woman was no longer essentialised.

Of the multiplicity of perspectives comprising postmodernism, as explored in her text *Feminism, theory and the politics of difference*, Weedon’s (1999:26) urge that feminists need to justify ‘the concepts we employ in the truth claims we advance’ was important to me. I had selected specific postmodern principles and integrated them with particular feminist principles for the interests of my investigation. Glass and Davis (1998:50) in their integrated feminist postmodern nursing research model refuted Heckman’s warnings for feminists not to simply take from postmodernism what they wanted. However, Heckman (1999), in my analysis, met Weedon’s (1999) call in her justification for multiple feminist epistemologies that took into account women’s differences, multiple realities, and which had the possibility to achieve cultural change that benefited women.

Heckman’s (1999) text, *The future of differences*, further deepened my insight into contemporary feminist postmodern approaches to the problem of difference as this emerged as a challenge to feminist standpoint theory in the 1990s. Heckman’s (1999) text significantly impacted upon me whilst I was critically reflecting on my process of transitioning from middle to executive level employment position. As an example, one comment from my reflective journal in 2003 was ‘How humbled I feel to have so many experienced and different women in
senior positions within this team. Each woman has shown immediate and unconditional support toward me as I start this new executive role with them.’ Heckman’s (1999) work, thus, impacted on my personal interest to create connective empowering professional relationships particularly with my experienced middle-level management team, all of whom were women (journal 2003).

What follows is an elaboration of the key features of Heckman’s (1990) proposal as I appropriated these with other eminent postmodern feminist theorists and scholars, such as those drawn from Patti Lather (1987-2000a, b).

**Difference – Background Assumptions and Its Impact on Feminist Political Action**

The way Heckman (1999) brought the issues of differences between women into the foreground of feminist theoretical consideration was useful. It enabled an appreciation of the different women nurses’ experiences within the patriarchally dominant hospital social setting. I explore Heckman’s work, within a detailed critical discussion in order to provide an understanding concerning the decision to draw from her work to understand the different self-managing strategies that MLWNs used within their work practice.

Heckman (1999) explored the key concepts of several principal feminist standpoint theorists’ perspectives, Hartsock, Haraway, Smith, and others. Heckman’s (1999:50) focus was to reveal their eventual discussion of ‘the social construction of reality and knowledge’ and the subsequent identification of the ‘multiplicities of standpoints’ within which multiple realities and differences between women could be recognised. Heckman (1999) supported feminist standpoint theorists’ eventual acknowledgement that difference was important. She also strongly challenged the pursuit and level of success of modernist feminism to establish a metanarrative of women’s knowledge as a counter point to the traditional rationalist’s metanarrative. In her view it would not significantly have changed the fundamental assumptions that influenced how people, especially men, viewed social reality (Heckman 1999). Heckman (1999:146 emphasis in original) argued that people’s taken-for-granted view of reality was shaped and constituted by masculinist assumptions and definitions which
comprised the ‘Background’, the beliefs by which people erroneously made ‘sense and meaning in our society’.

For my purposes, I interpreted Heckman’s (1999:124) use of the term ‘Background’ in a similar manner to that of culture. Culture was comprised of the dominant values of society which constructed how we viewed and behaved in the world. It’s meaning included that culture was ‘neither fixed nor finite but dynamic, expansive and intrinsically shaped by power and the struggle against it’ (Lather 1991c:xvi).

Although Searle’s (1995) philosophy was blind to feminist issues, Heckman drew from his description of Background as that which:

Enables linguistic interpretation to take place; it is the recognition and acceptance of a body of facts by the members of a society in which they are operative. This acceptance constitutes these facts; if it ceases, the facts themselves cease to exist. (1999:124)

Heckman (1999) argued for a different method by which feminists could breach the hegemonic epistemological social beliefs. Her perspective sought to alter the dominant beliefs by working with them, not against them, in order to align those beliefs more to feminists liking. Her point was not to pursue an alternative feminist metanarrative, rather to rearrange the elements of the dominant assumptions that were taken-for-granted in subtle ways thus changing the Background (Heckman 1999).

Although most postmodernists were averse to structured methodology and the pursuit of defining truth (Rosenau 1992), Heckman (1999) deliberately endeavoured to propose a transformative methodology that aimed to be political and interrupt the hegemony of Western epistemology. This also urged feminists to alter the definition of “Truth” to an epistemology that was ‘explicitly anti-foundational’ (Heckman 1999:120 emphasis in original). She argued that ‘the claim that truth can be achieved only through adherence to one rational, universal method is challenged by the care voice, the feminist standpoint, and women’s ways of knowing’ (Heckman 1999:120). She extensively argued that
the most critical challenge for feminists and other anti-foundationalists was to change the hegemonic masculinist social Background. She argued that this would create new meanings, a new social construct, and reverse the subjugation of women (Heckman 1999).

Heckman (1999) acknowledged that many feminists disregarded theories related to Background because they were conceptually grounded in masculinist assumptions and were conservative. Yet, Heckman (1999) convinced me to consider her proposal seriously as it closely related to my understandings of the taken-for-granted hegemonic medically oriented social constructs of the hospitals in which MLWNs worked. I viewed Heckman’s (1999) assertions, using the concept of Background, as a way to critically think about the ideology and discourses of bureaucracy as understood in our Western society. Her feminist notions drew my attention to the taken-for-granted male dominated structures, functions, power relations and culture implicit in public hospitals. Heckman (1999:146) spoke of using the ‘master’s tools to dismantle the master’s house’. This argument contrasted with what Chinn and Wheeler (1985:76) considered nurses too often do and that was to acquire the traits and emulate the ‘medical power model’. These different feminist scholars’ perspectives were important for me to bear in mind as I gained deeper understanding of how the MLWNs self-managed their subordinated nursing professional roles in contradictory circumstances of the medical and bureaucratic power models.

In the following sub-section I take further some of Heckman’s (1999) suggestions of how feminists could alter the hegemonic cultural Background to suit feminists’ interests.

**Feminist Strategies that may Transform the Background**

In a similar vein to that emphasised by Glass (1998) on the need to understand the theoretical frameworks of oppression, Heckman (1999) asserted that feminists must firstly understand the Background. From that position one can then develop change strategies, inclusive of ‘feminism’s insights into the workings of gender and power’, that would be ‘simultaneously incremental, connective, and transformative’ (Heckman 1999:123). This kind of creep-up and
creep-in transformation to Background assumptions sought to ‘redefine truth in terms that both connect to Background assumptions and at the same time begin the process of displacing those assumptions’. These feminist politically inspired actions, thus, provided an opportunity for a ‘new epistemology for differences’ and a new social construct (Heckman 1999:123). One of Heckman’s (1999:138) strongest suggestions was for feminists to ‘construct arguments that both make sense in terms of the Background and at the same time alter those terms by shifting their meaning’. In a practical way Heckman (1999:138) explicated this to mean: ‘making strange what appears familiar’. This method directly aligned with feminists’ critical reflective consciousness-raising strategies of challenging the taken-for-granted assumptions of our lived experience. With the women in my ethnography one of the deliberate strategies I used was to challenge or endeavour to ‘make strange’ what they understood as ‘familiar’ in their every-day practice within the patriarchally dominant hospital context. My interest was to facilitate, in a reflexive dialogic manner, consciousness raising and critical reflection of their contributions or resistive practices toward a culture that, as my assumption, needed to more vividly incorporate nursing values and nursing knowledge.

In respect to the way Heckman (1999) interrogated Searle’s concept of Background what I found important was that the hospital was one of Australian society’s iconic public institutions. The medical dominance of public hospitals was implicitly a masculinist social culture integral to the way nurses thought and behaved – consciously and unconsciously, as I highlighted throughout chapter two.

These long-experienced medical dominated assumptions constituted the reality of the working context and culture of the hospital. The reality was taken-for-granted. For the most part nurses were comfortable with this reality which was not easily challenged or changed, their nursing voice had been invisible and silent (Chiarella 2002). Historically, public hospitals, as bureaucratic institutions, epitomised subordinate worker behaviour in which staff deferred to the voice of authority, the hierarchically positioned doctor or administrator. It was initially the medical fraternity which established, embedded and institutionalised their culture and social rules into the hospital. More recently financially focused
administrators and corporate managers have persisted as the taken-for-granted Background, the cultural workplace context. Kagan (2006:318) noted of Ashley’s (1976) nursing research that, at that time, those who systematically exploited nurses, the second largest women’s workforce in America, ‘were instrumental in driving an economic and power agenda focused on enhancing the developing profession of medicine and the emergent rise of the hospital’. A hospital is not a hospital without nurses. And, although nurses constituted the largest number of hospital workers it was within such culture, in which the Background was so strongly patriarchally embedded, that nurses have had to learn how to survive and grow and to compete for their voices about nursing values to be heard.

Unfortunately, as highlighted by Heckman (1999:126), Searle did not proffer solutions to ‘how power maintains the status quo and how countervailing power might facilitate change’, but her interpretation of Wittgenstein’s Background theory did.

For Wittgenstein, as described by Heckman (1999:127), language was not only embedded in the Background but it also was ‘our form of life’. Heckman (1999:128 emphasis in original) pointedly drew from Wittgenstein’s (1958) argument in that ‘the ultimate justification for our claims to knowledge is not logic, but simply “what we do. It is what human beings say that is true and false; and they agree in the language they use”’. Heckman (1999) brought voices and behaviour as linguistic functions to the foreground. Voices and behaviour could be used by feminists to reshape patriarchy. The potential for this kind of subtle, but specifically political, transformative and marginally focused strategy influenced my thinking. It brought my attention to possible self-managing strategies that the MLWNs may/could/did use to change the hospital Background assumptions. It could assist to reveal ways that the MLWNs’ actions and voices became embedded as a taken-for-granted and evidenced in change in behaviour by health workers, especially by doctors, hospital administrators and corporate managers.

Heckman’s (1999:146) strategies to alter the Background did not imply confrontationally replacing one hegemonic culture with another. Rather she
challenged us to ‘use the parameters of what constitutes a sound argument’ as defined by the dominant group to shift the assumptions to effect change, that was, use the master’s tools to feminists advantage. It supported the notion that one or more nurse’s words and actions could change the hegemonic assumptions of medical dominance. The notion was that woman’s difference and her unique knowledge could be used in ways that were not so radically different to the dominant patriarchal language, thus, culminating in a change in the social and cultural assumptions.

Heckman’s (1999) proposal to change the Background in ways that fostered integrating the legitimising of women’s knowledge into the Background implicitly supposed that multiple paths to achieve desired change were not only possible but essential. I would call this kind of influence a creep-in and a creep-up empowering and transformative method. The creep-in and creep-up change processes seemed to be a very slow and unpredictable process, but one that needed to be in the repertoire for feminists and nurses. These local political feminist transformative notions formed important perspectives in my data analysis methods.

My interest to consider the MLWNs’ experiences of whether they pursued the creep-in/up kind of feminist transformative strategies within the patriarchal hospital culture raised my awareness that all feminist transformative strategies carried risks. Chinn and Wheeler’s (1985) concern alerted me to the possible risks when they argued that all too often, nurses sought to acquire physician skills and characteristics. That was, they endeavoured to take on the traits of their oppressors as a perceived means to gain power and professional status. Horsfall (1996) also made strong reference to this kind of modeling by subordinates of dominant behaviour. Another of Horsfall’s (1996:347) ideas that identified the risk for nurses was that often ‘subordinated people cannot discern or name their own positive attributes, let alone recognize excellence’. These notions were important as were Chinn and Wheeler’s (1985) further contention that such pursuits demonstrated that nurses lacked awareness of their own culture and this may have created a self-perpetuation of patriarchal oppression within nursing. This belief was further supported by other nurse researchers.
Sandra Harding (1990) stressed, in common with feminist postmodernists’ disenchantment, that feminists pursued their agenda in a constantly hostile environment because objectivism was the privileged dogma against which women and feminists were defensively excluded. The dogma of objectivism, in my interpretation, was an inherent feature of Searle’s (Heckman 1999:124) account of Background. For Searle, institutional and non-institutional facts, patriarchally shaped and enshrined, deeply influenced peoples beliefs and behaviours. The male gendered dominance that constituted my social Background, a Western culture and its various forms of oppression, may be perceived to have invincible barriers. However, both modern feminist and postmodern feminist approaches demonstrated an increasing ability to penetrate and infiltrate such barriers from the margins as well as full-frontal confrontation that positively reduced the exploitation of women.

Postmodern feminists took the matter of difference within the context of patriarchy into realms that specifically concerned my investigation. Heckman (1999), Weedon (1999), Harding (1990) and bell hooks (2000a) each emphasised that understanding difference, in its multiplicity of forms; between men and women; and between women, was important to advancing feminists’ political and social agenda. Difference was ‘not a sign of inferiority’ (Harding 1991:122). Doering (1992) also supported the benefit to nursing of drawing from feminist and postmodernist thought in that power and female experiences are incorporated within these theoretical perspective.

There were several other aspects of postmodernism’s methodological concepts of difference that emerged as relevant to my ontology and, thus, to the way I approached the ethnography. These are explained below.

**Difference – Multiple Perspectives within Postmodern Thought**

Through postmodernism I located an avenue that met my skepticism of truth claims and aspirations portrayed by modernist research assumptions. Rosenau (1992) noted that there were many different forms and orientations...
Postmodernism took from an extreme nihilistic view to that of more optimistic affirmative views. Rosenau’s (1992) and Lemert’s (1997) descriptions of theorists whose postmodern perspectives were more toward the nihilistic views, such as Baudrillard and Lyotard, confirmed that this orientation did not fit within my frame of values. Within the various affirmative postmodern concepts I found space to accommodate my research interests to valorise and celebrate the voices of individual MLWNs to the wider health professional community.

Rosenau (1992) asserted that postmodern thought was highly contentious. Its notions upended all the taken-for-granted understandings and assumptions of how we live and function within a Western culture, like Australia. It is my belief that the multiplicity of postmodern viewpoints and the contradictions within its perspectives had opened up new, exciting and creative options for feminist social science research and social change.

In her text, *Post-Modernism and the Social Sciences*, Rosenau (1992) developed various facets of postmodernist ideas without expressly privileging particular features over another. Rosenau (1992) acknowledged, like Lather (1991c) and Cheek (2000) that postmodernism within the social sciences was a highly contested site for the way we had come to understand and make meaning of our experiences and the world around us. For Rosenau (1992:5) ‘post-modernism [neither] proposes to set itself up outside the modern paradigm, not to judge modernity by its own criteria but rather to contemplate and deconstruct it’ nor to replace one hegemonic ideology with another. The social science endeavour was rearranged by postmodernists by rejection of the ‘logocentric, transcendental totalizing meta-narratives’ (Rosenau 1992:6). It was thus in stark contrast with the predictive and causal nature of modern Western positivist science with which humans were to be liberated ‘from ignorance and irrationality’ (Rosenau 1992:5). Rosenau (1992) noted that postmodernism evolved as a critique and challenge of modernist’s belief in progress especially in light of the world’s disasters like the numerous wars of the 20th century and the impact on human life and experience. In Rosenau’s words:

> Post-modern social scientists support a re-focusing on what has been taken for granted, what has been neglected, regions of resistance, the
forgotten, the irrational, the insignificant, the repressed, the borderline, the classical, the sacred, the traditional, the eccentric, the sublimated, the subjugated, the rejected, the nonessential, the marginal, the peripheral, the excluded, the tenuous, the silenced, the accidental, the dispersed, the disqualified, the deferred, the disjointed. (1992:8)

Julianne Cheek (2000), in her text *Postmodern and poststructural approaches to nursing research*, explored how postmodern ways of thinking about the world could influence nursing research. She highlighted the plurality of postmodern thought which acknowledged the multiplicity of realities and multiple means to making sense of the world and our experiences. For Cheek (2000) the multiplicity of postmodern lens’ opened the possibility to view any aspect of reality, inclusive of health care.

My ethnography was more than an opportunity to explore and describe the overt cultural context of the lived reality of MLWNs. It was focused on the unsaid, unconscious, forgotten and hidden aspects of their practice world. It was within this context that I sought to uncover and understand the multiplicities of what their world was like from their perspective. Inherent in these ideas was Lather’s (1989:19) research challenge in that ‘the focus is on how we are inscribed in dominant discourses, how we are inserted and insert ourselves in the constructions of hegemonic meaning systems’. Further, I drew from Lather’s (1991b) feminist postmodern methodological recommendations (Table 28. ‘Pertinent feminist postmodern research criteria’). These criteria provided a supportive frame of the empowering methodological considerations for my study.
Table 28. Pertinent feminist postmodern research criteria (Lather 1991b).

<table>
<thead>
<tr>
<th>Year</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991b:17</td>
<td>Put the social construction of gender at the centre of one’s inquiry. The research is openly ideological and critiques the politics of knowing and being known.</td>
</tr>
<tr>
<td>1991b:21</td>
<td>The research methodology explicitly aligns with the theoretical and political commitment.</td>
</tr>
<tr>
<td>1991b:5</td>
<td>The insertion of the researcher reflexively constructing the knowledge with the researched.</td>
</tr>
<tr>
<td>1991b:19</td>
<td>To take the analysis further than a description of the women’s experience of their reality while retaining their multiple subjectivities.</td>
</tr>
<tr>
<td>1991b:22</td>
<td>Reduce the risk of the researcher ‘objectifying’ the women as research objects and my becoming the authorial expert of their experiences by using a participatory data analysis process with the participants.</td>
</tr>
<tr>
<td>1991b:24</td>
<td>The design of the research is ‘for’ women not ‘about’ women and is drawn from their experience of their world.</td>
</tr>
</tbody>
</table>

In concert with Lather’s (1991b) suggestions was Cheek’s explanation of the questioning and challenging approach that postmodernists had toward what people, such as health professionals, took-for-granted or normal in that:

Postmodern approaches allow for the possibility of exploring how the practice setting came to be constructed in the way that it is. What are the assumptions and understandings of health care practice that are taken for granted which have shaped the way practice settings operate? Whose assumptions and understandings are they, and why are other views excluded or marginalized? (2000:6)

Lather (1991b) and Cheek’s (2000) postmodern notions, such as the possibility for multiple ways to understand the social world, seemed to me to articulate with Heckman’s (1999) proposal to first critique and challenge the dominant Background or culture and develop different ways to breach it in order to change it.

Postmodernism rejected the modernists’ view of authorial privilege. Therefore, the notions of representation, text, intertextuality, multiple meaning-making, and multiple subjectivities were concepts which became integral to my ethnography. These concepts are discussed in the next sub-section.
**Difference – The Postmodern Impact on Representation and Multiple Meaning-Makers**

Language and the discourses that held the power and authority to frame or represent the context of our understanding and meaning, our self-view and how we are viewed by others also came under scrutiny by postmodern critique (Cheek 2000). Postmodernists’ repudiated anything that sought to represent singularity of things, people, places, or time because the concept of representation presupposed that the ‘transference is made without loss of content or violation of intention’ (Rosenau 1992:93). As a crisis of representation Lather asserted the following:

> Whatever “the real” is, it is discursive. Rather than dismissing “the real”, postmodernism foregrounds how discourses shape our experience of “the real” in its proposal that the way we speak and write reflects the structures of power in our society. (1991c:25 emphasis in original)

Cheek (2000) and Lather’s (1991c) challenges brought into focus critically important aspects of postmodernism. These were notions related to discourse and representation: language and text, intertextuality, multiple meanings, and reflexivity. These collective notions inherently valued and celebrated differences and were particularly linked with my research interest.

Text, as a postmodern notion, was viewed by Savage (2000b:frame 1) ‘as anything articulated as language’. Text did not ‘carry a single or unified meaning imposed by the text’s author, but that the plurality of meanings in a text become fused by the reader’ (Savage 2000b:frame 1). This notion implied that the author’s privilege was replaced by the reader as the key meaning maker of text (Rosenau 1992). Extending the notion of text it was Wong Woon Hau (2004:4) who asserted ‘people present themselves as a constructed text’ and through which their realities are articulated. Rosenau (1992) noted that life experience was also viewed as text.

Postmodernism emerged as a response to a crisis in representation (Cheek 2000; Rosenau 1992). An underpinning postmodern perspective was that it was impossible to recreate reality, speak on behalf of another person or group, gain
any essentialising understanding or assert truth claims. Further, it could only ever be a partial analysis and representation as it drew from one, not every possible, perspective. In the context of affirmative postmodern thinking, I acknowledge that I held no privilege to being the only meaning-maker of the MLWNs' lived realities, as constructed text.

These postmodern notions were also supported by Glass and Davis (1998) in their approach to nursing research. For Cheek (2000) and Glass and Davis (1998), not only did postmodern approaches embrace multiple voices, multiple realities, and multiple views, it also recognised multiple analytic methods. Of alternate analytic understandings Lather’s (1991c:94 emphasis in original) quote from Patai (1998) claimed that texts ‘were “a point of intersection between two subjectivities” which could easily have produced a different story with different emphases given different interview [and participant observation] conditions’. What postmodernism potentially offered, as articulated by Cox Dzurec (1989:76), was that it ‘encourages us to look beyond what we know to focus on the forces that limit what we can know.’ These notions provided important constructs for my interest of an emancipatory focus for the ethnography.

As Cheek (1995:239) also pointed out, in her reference to representations about nursing, nurses needed to ‘recognize that reality is composed of multiple contradictory voices which for various reasons surface at certain moments’. These notions aligned with postmodern understandings of language, discourse, and Heckman’s (1999) concepts of Background.

Allen’s description of postmodern intertextuality concisely clarified that all my ethnographic data could be viewed as text:

Intertextuality reminds us that all texts are potentially plural, reversible, open to the reader’s own presuppositions, lacking in clear and defined boundaries, and always involved in the expression or repression of the dialogic ‘voices’ which exist within society. (2000:209)
Positivist modernist research methodology presumed authentication of the researcher’s assumed right to represent or speak for others because of their objectivist stance, ‘the identity of the “knower” (i.e., who the scientist is) is not especially relevant’ (Campbell & Wasco 2000:frame 6 emphasis in original). It also incorporated the polarising of the subjective and objective concepts in which this dichotomy hierarchically positioned the authority of one over another (Rosenau 1992). Postmodernists rejected the modernists’ stance that designated, as a hierarchy of privileged voice, the observer as subject because it ‘relegates those being studied to object status’ (Rosenau 1992:49). The implication for the subordinated position of the researched, as the object of study, meant that they had no legitimacy to author their own meaning of their reality. Further, postmodernists rejected the researcher’s role of ‘universalizing spokesperson’ (Cosgrove & McHugh 2000:frame 9). Rosenau (1992:50) pointed out that affirmative postmodernists argued that humans were objectified by the positivist scientific lens. Of this stance, in her view, feminists considered this as oppressive and, thus, denied any positive distinctive status to women’s lived experience (Rosenau 1992). It was from my position as ethnographer that this concept was very significant. My interest was to align with feminists’ non-hierarchical, non-objectified, reflexive relationship with research participants. To have the MLWNs’ voices and narratives centred and validated in the thesis and their multiple subjectivities valued while also acknowledging that as researcher I was an integral part (Bruni 1995) of the process.

Taylor and White (2000), in respect to health professional’s reflexivity skills, argued that in order for people to have a credible voice they purposefully constructed facts to create certain effects in dialogue with others. Alvesson and Sköldberg’s (2000) notion of reflexivity consisted of complexly interwoven processes of knowledge production, the knowledge producer and the context for knowledge construction. Pellatt (2003:frame 1) noted that reflexivity enabled her, as the researcher, to ‘acknowledge my taken-for-granted values and consider how they impinge on both my research and my practice’. Within the context of constructing my ethnography reflexive dialogue and critical reflective thought with the women participants were principal features. My interest was to reflexively reveal their insights and for them to gain enhanced awareness and
confidence that their knowledge was valued and valuable to other women nurses.

Taking this notion into a feminist reflexive research approach Lather’s (1991c) perspective of reflexive practice located the important learning point as one moved from critical thought to emancipatory action. The reflexive move involved understanding the political impact of what is done or not done at the practice level. The benefits of such reflexive emancipatory processes, and which are further detailed in section five of this chapter, was further asserted by Lather in that:

Emancipatory knowledge increases awareness of the contradictions distorted or hidden by everyday understandings, and in doing so it directs attention to the possibilities for social transformation inherent in the present configuration of social processes. (1991c:52)

How postmodernism viewed the author and reader of text were concepts that I also encompassed within an overarching view of representation. From Rosenau’s (1992:25) description, the postmodern reader ‘is given the freedom to attribute meaning to the text without consequence or responsibility’. How ‘real’ or ‘true’ was my representation of the MLWNs’ lived realities and emergent insights from data analysis was also a question of validity. Validity is a quintessential feature of modernist research (Wainwright 1997); the conditions that legitimate knowledge and, therefore, claims to truth. In section five of this chapter I explore in more detail the issue of validity associated with this thesis. However, at this point in the discussion, Brewer’s (1994) assertion of the role of an ethnographer was pertinent. He argued that, ‘at best an ethnographer (like all social scientists) can only persuade the reader to agree that the explanation is a plausible one, but not that it is the only plausible one’ Brewer’s (1994:243 emphasis in original).

The possibility for multiple interpretations of my ethnography did not unsettle me as my interest was that people take from any prospective learning situation that which has personal meaning to them. From a postmodernist perspective I was aware of the dilemma of my authority and privilege as the writer of this
thesis. My ideas and explanations may have multiple alternatives and possible contradictions. So too did I appreciate that readers of the ethnography may also view the text for what it failed to reveal (Rosenau 1992).

In the next sub-section I further discuss the different ways postmodernism challenged modernist notions of subjectivity and how this was a dilemma for modernist feminists.

**Difference – Postmodernists’ Subjectivity and the Dilemma for Feminism**

Heckman (1990) drew together the commonality of both the feminist and postmodern challenges toward modernity’s dualisms. Heckman (1990) problematised the endeavour to align feminism and postmodernism pursuits. She highlighted that feminism was linked with Enlightenment’s ‘adherence to dichotomies and absolutes’ and yet ‘feminism has much in common with postmodernism’s criticisms on Enlightenment epistemology because it places women in an inferior position’ (Heckman 1990:6). The centrality of androcentric bias in modernist science meant that ‘women’s lives and experiences have not been adequately captured’ (Campbell & Wasco 2000:frame 4).

At the heart of modernity’s situating of dualisms was rationality in which modernity ‘abstracts the knower from the known’ and the knowledge generated was ‘for rationalism, definitive of truth’ (Heckman 1990:12). The modernist concept of the rational refers specifically to male logocentrism and, thus, ‘woman is always defined as that which is not man’ (Heckman 1990:31 emphasis in original). Heckman (1990:31) further asserted that ‘through their control of language, men have dominated not only women but every aspect of the world in which we live’. This domination of male-centred language was contested by both postmodernists and feminists who asserted that such ‘discourses that create knowledge create reality as well’ (Heckman 1990:33). To this stance could be added modernity’s Cartesian dichotomy between object/subject in which the search for universal and absolute truth was ‘firmly grounded in the rationality of the knowing subject’ (Heckman 1990:62). Therefore, Descartes’ modern man was the constituted and centred rational knowing subject and woman was the marginalised subjugated object.
The more skeptical social science postmodernists ‘reject both subjects *and* objects as essential entities and, with them, the goal of absolute knowledge’ (Heckman 1990:64  emphasis in original). For feminists, however, there was a mixed reaction to the postmodern position to discard the modernist’s humanist and Enlightenment conceptualisation of the subject. Primarily, this was because their efforts had been directed toward ‘bringing women into the realm of the subject’ (Heckman 1990:74) that was, out of the role of man’s other or object. The dilemma was that within the frame of either humanism or Enlightenment the privilege of rationality was attributed only to men, not women, as they were considered inferior (Heckman 1990:6). Hartsock was among the strongest feminists to dispute the potential benefits of postmodernists’ dissolution of subjectivity in her comment:

> Why is it that just at the moment when so many of us who have been silenced begin to demand the right to name ourselves, to act as subjects rather than objects of history, that just then the concept of subjecthood becomes problematic? (1990:163)

In response to Hartsock’s (1990) concern I found Van Loons’ (2001) discussion of difference relevant. Van Loon (2001:278 emphasis in original) noted that the category ‘woman was held as “the” (universalized) subject of feminism, [and] was itself an homogenized construct that masked fundamental divisions which were as important as those between women and men’. He asserted that this was a cultural construct that subjugated ‘women of colour, lesbians and women within working-class movements’ (Van Loon 2001:278).

The postmodern subject’s focus was more toward the margins of ever-day life (Rosenau 1992). This localised focus was applicable to my assumptions that the MLWNs’ roles and responsibilities on a daily basis were similar, but whose experiences were uniquely different. How they managed their life at work, I assumed, was also not universal. Rosenau’s (1992:57) description of postmodernists’ subject was relevant. I believed that nurses were effective thinkers and knowledge creators. My assumption included that nurses were skeptical of totalising theories, such as those derived from medical science. The basis for my assumption was that health research and human response to
health and health disruptions was dynamic; notions supported by nurse scholars such as Linda Shield (2001). Further, nurses practice in and out and in-between differing and competing subjectivities (Manias & Street 2001a). Thus, my assumptions paralleled Rosenau’s comment that the postmodern subject, the nurse in this context, ‘will reject total explanations and the logocentric point of view that implies a unified frame of reference, but s/he need not oppose all dimensions of humanism’ (Rosenau 1992:57).

The notion of postmodern human subjectivity as mobile was developed further by Ogle (2004) in her feminist postmodern ethnography, where she applied this concept to her research with critical care nurses. Of this mobile subjectivity concept Ogle (2004) described her own state during her research. She noted that ‘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 alternative views or troubling apparent given constructs’ (Ogle 2004:154 emphasis in original). Farganis (1994:119) also affirmed a positive notion of postmodern thinking about women in that, ‘women are seen not to constitute a single identity but many diverse identities in a larger social context’.

Critical social science sought to free humanity from the pain of life (Fay 1987). Moreover, Rosenau (1992:59 emphasis in original) drew from Giddens’ (1990) concept of the postmodern subject in which Giddens proposed ‘a subject who looks for “freedom to” have a fulfilling and satisfying life’. This view was proactive and optimistic. This kind of liberatory ‘freedom to’ postmodern subject, with its optimistic flavour, fitted closely with my values and impacted upon the way I viewed the MLWNs’ experiences.

In section five of this chapter I further explore the concept of subjectivity in its difference/opposition to objectivity in the ethnographic method. The application of postmodern perspectives within nursing research was a site of contention and contestation and the following discussion illustrates some of the arguments.
Criticisms of Postmodern Epistemology in Nursing.

A cautionary note was raised by Strickland’s (1994) feminist criticism of postmodernism. She commented that ‘the local level should never be trivialized or ignored, [but] it has to be seen within the wider context to be understood more adequately’ (1994:269). In particular this was relevant for me to consider when undertaking analysis of the potential bureaucratic power differentials I assumed were evident, pervasive and typical within the power plays present within societal institutions (Strickland 1994). Responding to this kind of broad contextualisation of difference formed part of my purpose for including, in chapter two, discussion of the government and nursing professional issues present at the time of the ethnography. One of my research assumptions was that the broader sociopolitical context may/may not have partially framed the experiences of the MLWNs.

I also took note of Kermode and Brown’s (1996) highly skeptical stance concerning the value of postmodernism to nursing epistemology. Their analysis endeavoured to demonstrate that postmodernism was a ‘hoax concocted by white bourgeois patriarchy to divert women and other oppressed groups from participating in the Enlightenment project, while the real narrative rolls on relentlessly – capitalism, patriarchy and power’ (Kermode & Brown 1996:380). These scholars seriously questioned the social significance of knowledge produced by postmodernist thinking. Contrary to this, Reed (1995:70) argued for the benefit of a model that ‘builds on the accomplishments of modernist nursing while exploiting opportunities of the postmodern context’. In contrast to Kermode and Brown’s (1996) criticism, I believed feminist postmodern epistemological endeavours did not foster notions of forfeiting the future. Instead, I believed it opened up different ways for nurses to better understand themselves and their experiences and to have affirmed their own knowledge creativity.

As Walker (1994:163) affirmed, feminist postmodern insights ‘open up possibilities through critique at multiple levels and allow us to rewrite the epistemological codes which have hitherto constrained the meanings available to us’. Glass and Davis (1998) also argued that the possibility for postmodernism’s emancipatory intent would be denied if all postmodern
accounts were explained by nihilistic and relativist postmodern thinking. For me, feminist postmodern thinking increased women’s personal resources to pursue emancipation. Further, I believed it could effect change within the patriarchally dominated culture such as the health arena, epistemologically and culturally.

**Summary of Section 3. Integrated Feminist Postmodernism - Revisioning for Nursing Research Methodology**

In section three I deliberately and extensively discussed various fragmentary aspects of postmodernism and its suitability for integration with feminist principles. I believed this integrated methodology afforded a new, different and untapped research space for valuable and legitimate nursing knowledge to be revealed (Glass 2007). Glass and Davis’ (1998, 2004) integrated feminist postmodern framework within nursing practice research was unfamiliar and new to contemporary nurse researchers within Australia. Glass and Davis’ (1998:50) framework offered a ‘refocusing to encompass an emphasis on the contexts that create meaning combined with a revisioning to the point where everything is open to interrogation’. Thus, there was a possibility to destabilise, disrupt, upend, and alter what Heckman (1999) called the Background and its historically patriarchal oppressive domination. This integrated research framework proffered an opportunity to reveal, celebrate and legitimate women nurses’ unique knowledges of their sociopolitical experiences within their professional and corporate work contexts.

Glass and Davis’ (1998, 2004) integrated feminist postmodern philosophical considerations for nursing research was the prime framework for my investigation. They (Glass & Davis 1998:45) asserted the emancipatory value of feminist research processes, inclusive of their own feminist research with nurses, as giving voice to women, thereby, ‘freeing women from past oppressive experiences’. One possible solution to oppression, in their view, was the verbalizing of such experiences that occurred with the sharing and reciprocity between the feminist researcher and women participants (Glass & Davis 1998). These nurse researchers rejected the generalised monolithic theorisation of modernism. They considered there were many aspects of the oppression narratives as inherent in feminist modernism that were supported within postmodernism. Such feminist notions included the centering of the
researchers’ struggle ‘to equalize power by validating individual difference among women and nurses, while simultaneously recognizing the importance of unity concerning transforming oppressive states’, as a means for ‘a coherent movement for social change’ (Glass & Davis 1998:46). Of critical social feminists’ deconstruction and valuing difference perspectives, Glass (2007) and Glass and Davis (1998:46 emphasis in original) questioned its limits, and asked if it was possible ‘for all women to be transformed and all women to become empowered’.

Glass and Davis (1998:48) sought to take an interdisciplinary and supplementarity approach, rather than a dualistic and separatist view. They drew upon ideas from ‘within the nursing literature, feminist postmodernism and postmodern sociology for the development of the integration debate’. Such an integrated ‘turn’ also provided a ‘renewed attention to objectivity, reliability and validity in research (Parsons 1995 in Glass & Davis 1998:48). Of value to nursing research, Glass and Davis’ (1998) feminist framework inter-connected with postmodernism brought forth the notions of power and subjectivity. This ‘turn’ was helpful in ‘identifying the strategies of medical dominance, nursing submission and resistance, and assist with the emancipatory intention to destabilize organizations and structures’ (Glass & Davis 1998:49). Further, it opened the way for consideration of ‘individualized and context-specific experiences and subsequent [transformative] strategies’ (Glass & Davis 1998:49).

Glass and Davis’ (1998:49) proposed integrated feminist postmodern framework celebrated women’s difference and voice through its validation of ‘the socially constructed nature of existence, blur[ring] of boundaries, and acknowledge[ment] of the need for dialogue or conversation rather than an authoritative voice’. This perspective gave women’s voice ‘new scripts, texts and discourses’ (Glass & Davis 1998:49). Integral to this research methodology proposed by Glass and Davis (1998:50) was ‘a resituating of perceptions of identity, subjectivity, agency, language, and power’.

My principal theoretical framework for the ethnography was informed by Glass and Davis’ (1998, 2004) model. In addition, many features from critical social
science, radical feminism and affirmative postmodernism also informed the multiple lenses through which I approached the ethnography. Critically relevant to informing the ethnography were Foucault’s (1980) notions of power/knowledge, self-surveillance and governmentality. These Foucauldian notions are explored in detail in the next section.

**Section 4. Foucault’s Influence on the Ethnography**

In a further rebuttal to Kermode and Brown’s (1996) cynicism of postmodernism in nursing, it was relevant to consider how Foucault’s (1980) knowledge/power and technologies of self (1988) concepts positively influenced the work of some feminist postmodernists. Particular Foucauldian perspectives also informed the way I viewed the ethnographic data and which became crucial in my data analysis along with Lather’s (1991b) perspectives.

Pertinent to my discussion to follow of Foucault’s (1980) notions of power/knowledge I drew a distinction between his notions and that proposed by Kincheloe and McLaren (2005) concerning the conceptualisation of power within contemporary critical social theory (as previously discussed in section one of this chapter). Three key assumptions to which Kincheloe and McLaren (2005) referred were: firstly, that power was socially and historically constituted; and secondly, that some groups were privileged over others. The third assumption, however, troubled contemporary critical theory. Their assumption was that ‘although the reasons for this privileging may vary widely, the oppression that characterizes contemporary societies is most forcefully reproduced when subordinates accept their social status as natural, necessary, or inevitable’ (Kincheloe & McLaren 2005:304 emphasis added). My disagreement was that such notions of power, as proposed by criticalist researchers, assumed that oppressed people were devoid of any power within the relationship with their oppressor/s and thus could not change their circumstances themselves. Change could only occur by way of the criticalist’s privileged knowledge or theory.

Thus, it was within Foucault’s works (1980) that I found my assumptions of power/knowledge relationships fitted more coherently. The possibilities for the oppressed to productively change the effects of their oppression at both an
individual and collective level without authorial intervention allowed for a different notion of power. In Foucault’s (1980:142) words, ‘there are no relations of power without resistance’. This notion, in my view, encompassed self-managing strategies that could also be politically productive.

Foucault refuted being a postmodernist (Cheek & Porter 1997; Falk Rafael 1996; Foucault 1988; Huntington & Gilmour 2001). McHoul and Grace (1993:vii emphasis in original) viewed Foucault as a theoriser ‘who does philosophy as an interrogative practice’. It was Foucault's interrogative questioning and skepticism of authority, political and cultural norms and metanarratives that proclaimed truth, which had been useful to feminists’ political activism to transform oppressive power.

I was also drawn to the way Falk Rafael (1996:frame 2) claimed that Foucault viewed the historical creation of human beings as ‘objectified, or made into subjects, in our culture’. Barker (1993:76) collated Foucault's work around three relations: ‘to truth games; to others; and to self’. These three relations, as Barker (1993:76) noted, ‘each represents a drawing of the subject: the subject of science, the subject of power and the subject of techniques of self . . . The subject is simultaneously both the subject and object of the power/knowledge relation’. Of further relevance was Barker’s (1993:77) explanation of Foucault’s subject as ‘an effect of the interplay of tactics and strategies on the power/knowledge network which produces self-knowledge from the multiplicity of possible subjections’. The connection that Barker (1993:78) made of Foucault’s notion of truth was that it is ‘no more than the result of the rules in operation at the time and in the place that it emerges’.

Foucault’s major works (1972 - 1994) emerged at a similar time as that of second wave feminism, in the 1960s and onwards. Like Cheek and Porter's (1997:109) comment I also found Foucault's writings and perspectives to be ‘notoriously complex, divergent and multifarious’. There were significant tensions and distinctively different insights between feminist and Foucauldian analyses. Foucault did not make any reference to women’s issues, or of the feminist movement (Boyne 1990; Martin 1988). However, the commonalities between feminism and Foucault’s propositions formed points of resistance that
were taken up by contemporary feminists (Cheek 2000; Cooper 1994; Diamond & Quinby 1988; Lather 1991b; Lawler 1991; Ogle 2004; Street 1992) in ways that enhanced the feminist agenda of social criticism and social change. Diamond and Quinby early feminist adopters of Foucault's ideas, specified four commonalities worth noting of feminism and Foucault's notions:

Both identify the body as the site of power, that is, as the locus of domination through which docility is accomplished and subjectivity constituted. Both point to the local and intimate operations of power rather than focusing exclusively on the supreme power of the state. Both bring to the fore the crucial role of discourse in its capacity to produce and sustain hegemonic power and emphasize the challenges contained within marginalized and/or unrecognized discourses. Both criticize the ways in which Western humanism has privileged the experience of the Western masculine elite as it proclaims universals about truth, freedom, and human nature. (1988:viii)

Foucault's (1980) deconstruction and explication of power/knowledge proposed that these notions were never separable and were evident within each society. Subjectivity was situated as an effect of power relations. The interrelationship between power and knowledge meant that ‘knowledge is an instrument and technique of power relations’ (Manias & Street 2001b:131). As Diamond and Quinby (1988:x) articulated, Foucault's power/knowledge notions foregrounded ‘the complex network of disciplinary systems and prescriptive technologies through which power operates in the modern era, particularly since the normalizing disciplines of medicine, education, and psychology have gained ascendancy’. Cheek (in Cheek & Porter 1997:109 emphasis in original) argued that Foucault suggested that the dominant scientific/medical discourse should be acknowledged as ‘embedded within which is the power/knowledge that both produces and maintains such dominance’. Cheek's (in Cheek & Porter 1997) interpretation was that Foucault did not suggest this discourse be removed, or replaced.

Inherent within Foucault’s power/knowledge notions was language, as discourse, in all its forms (bodies of knowledge) (Delanty 2000). For
postmodernists, and as discussed in the previous section, language was considered constitutive. Language ‘shapes knowledge, in contrast to the notion that language is merely reflexive of some pre-existing material entity’ (Weedon 1987, in Huntington and Gilmour 2001:902). Diamond and Quinby (1988) noted that language for feminists, as discussed in the previous two sections, was that of men’s discourse. Huntington and Gilmour (2001) explored how Foucault’s concept of adding the dimension of power to discourse created new opportunities for feminists. Feminists could view power ‘as discursively constructed, rather than being an oppressive force that requires a victim’ (Huntington & Gilmour 2001:903). It also meant that power and knowledge were not fixed entities. They were ‘technique[s] of power and social administration’ (Mansfield 2000:64). These were prospects that had positive implications and possibilities for nursing. These notions became crucial considerations in my analysis of the participants’ experiences.

Ogle (2004) interpreted Foucault’s power construct as that of a network of power relations. Her interpretation of this Foucauldian construct was ‘rejecting [of] the top-down approach of those with power oppressing those without power’ (Ogle 2004:148). Foucauldian power ‘is exercised and it operates in all directions’ (Taylor 2002b:344). Weyenberg (1998:frame4) understood Foucault’s description of power ‘as exercised, circulating, and existing only in action, as opposed to power as a possession’. Further, of Foucault’s position on freedom from oppression, Clarke (1996:260) commented that it ‘comes from discourses that focus on how knowledge – the primary source of power – is produced and used at particular sites’. These notions also were particularly pertinent to my ethnographic analytic focus.

As a continuation of the discussion in the previous section of nurse researchers’ criticisms toward postmodernism the following sub-section extends this critique. In the next sub-section the critique is in relation to issues about Foucault’s theoretical notions.

**Counter-arguments for Foucault’s Benefit to Nursing**

The reflexive dialogue between Cheek and Porter (1997) of their opposing opinions about Foucault’s value to nursing and health care was pertinent to
understand my data analytic perspectives. From Cheek’s perspective a Foucauldian analysis had the possibility to ‘expose otherwise taken-for-granted assumptions as discursively framed’ (Cheek & Porter 1997:113). Further, that this form of analysis explored ‘the effects of power, understanding the way power operates’ (Cheek & Porter 1997:114). For Cheek, this view ‘involves nurses working “with” power rather than “against” it’ (Cheek & Porter 1997:114 emphasis in original). Cheek’s challenge to Porter, was ‘Why can there not be a multiplicity of positions from which to analyse and critique aspects of reality?’ (Cheek & Porter 1997:113). Among Porter’s counter-arguments against Cheek’s propositions was his concern of Foucault’s extreme relativism (Cheek & Porter 1997). Porter’s concern was that, although it identified what was wrong with our current situation ‘it can tell us very little about where we should go’ (Cheek & Porter 1997:113). Porter was skeptical of Foucault’s benefits for nursing when he claimed that ‘nursing, with its responsibilities concerning best practice, should be wary of such relativist negativity’ (Cheek & Porter 1997:113). Porter’s arguments were useful because he raised my awareness that knowledge, such as that established from modernist scientific work, (and thus, what modernist feminist research had also foregrounded) should not be totally dismissed.

Cheek (2000:23) described Foucault’s concept of discourses as ‘frameworks which order reality in a certain way’. Discourses constructed how we think about reality, how knowledge was produced and what constrained the production of alternate knowledge or ways of thinking (Cheek 2000). How discourses were accepted as ‘truth’ was a political action and a taken-for-granted effect of the dominant power. For Foucault power was both a productive and repressive concept and a network (Cheek 2000). It was not ‘a dichotomy between those who have power and those who do not’ (Cheek 2000:35). Martin (1988:9) noted of Foucault’s concept of power as ‘a multiplicity of force relations’ and resistance arising from multiple points.

In my opinion, as we emerged into the twenty first century Foucault’s concepts had even more relevance to nursing within the feminist perspective. My understanding was that nursing was still powerless (or in a Foucauldian frame, it was repressed) within the health decision-making arena (Pinch & Della 2001).
It was also repressed in the legitimacy of its knowledge because the dominant discourses continued to position nurses as outsiders (Chiarella 2002). Further, it shaped what nurses’ knew of themselves and of nursing, as Cheek (2000) and other nursing scholars (Glass 2003a, b; Ogle 2004; Paliadelis 2006) continued to highlight. It became apparent to me that a postmodern gaze could benefit contemporary nursing knowledge. A postmodern gaze sought to examine taken-for-granted understandings and discourses within which people undertook to do their work. They had the potential to mobilise either a productive or resistive approach or all/any aspects of this ‘non dichotomy’. They, therefore, had the opportunity to think differently about their reality. Either action was transformative and formed the basis for strategic action. Also, within Foucault’s explanation of discourse, as described by Cheek and Porter (1997:119 emphasis in original) discourses did not exist apart from their ‘socio-historical context. . . The status and dominance of a discursive framework is a product of power relations’.

The following two descriptions of Foucault’s notions of power were integral to my ethnographic analytic considerations. Firstly, Foucault’s conception of power:

Power must be analysed as something which circulates, or rather as something which only functions in the form of a chain. It is never localised here or there, never in anybody’s hands, never appropriated as a commodity or piece of wealth. Power is employed and exercised through a net-like organisation. And not only do individuals circulate between its threads; they are always in the position of simultaneously undergoing and exercising this power. In other words, individuals are the vehicles of power, not its points of application. (1980:98)

Of equal importance to me was Townley’s interpretation of Foucault’s postmodern explanation of power:

Power is not something that is acquired, seized or shared, something one holds onto or allows to slip away. Rather, power is relational; it becomes apparent when it is exercised. The exercise of power
perpetually creates knowledge and, conversely, knowledge constantly induces effects of power. It is not possible for power to be exercised without knowledge, it is impossible for knowledge not to engender power. (1993:frame 2)

Cooper (1994:436) endeavoured to theorise an ‘ethics of power’. This theory had the possibility of both negative and positive intentions. She proposed strategies for change and transformation may be possible. Cooper (1994) described a Foucauldian feminist view of power which incorporated the notion that power was productive and repressive.

Huntington and Gilmour (2001) developed their argument in support of postmodern feminist analysis in conjunction with Foucauldian critique. They explored typical nursing education texts to reveal the hegemonic medical focus and which overtly or covertly had a political intent to marginalise nursing knowledge. Personal experiences (like that of MLWNs) were rarely heard and this paralleled the theories of management discussed in chapter three.

Although I considered Foucault’s theoretical notions as appropriate to apply within the context of my ethnography, I was also very aware that his ideas, like all theorists, had significant limitations (Carspecken 2003; Fraser 1989; Kermode & Brown 1996). His notions should not be accepted as any kind of truth claim. Rather, they should be seen as a frame of reference to understand the social relationships within which people may live their lives.

Pursuing further some of Foucault’s postmodernists notions, in the next sub-section I explore his concepts of the clinic, governmentality and the panoptic gaze.

**Foucault – The Clinic, Governmentality, Panoptic Gaze and Self-Surveillance**

Foucault’s exploration of ‘the Clinic’, ‘Governmentality’ and the ‘Panoptic Gaze’ (Cheek 2000:26-28 emphasis in original) created a reflective hiatus for me of what I had always experienced as a practicing nurse, educator, researcher and manager. These three Foucauldian concepts, in my view, played critical roles in
the way nurses have had to juggle the disjunctions, tensions and oppositions between the dominant medical and bureaucratic practices and that of their subjugated nursing models of thinking. Foucault’s (1973) description of the Clinic institutionalised the medical gaze and thus objectified the body ‘within the parameters of the scientific/medical discursive frame’ (Cheek 2000:26; Lawler 1991; Street 1992).

Of Governmentality, Cheek (2000:27) described Foucault’s (1979) explanation as ‘characterised by pervasive matrices of power which entail the surveillance and disciplining of both individuals and entire populations: the population is both subject and object of government’. Gordon (1991:2) noted that Foucault understood the term ‘government’ in both a wide and a narrow sense. He defined it as ‘meaning “the conduct of conduct”: that was to say, a form of activity aimed to shape, guide or affect the conduct of some person or persons’. The concept included ‘the government of one’s self and of others’ (Gordon 1991:2). Nurses, as well as other health professionals, were under constant surveillance by their own reflective practice, performance measures by employing bodies, professional registration bodies, peer review and their patients. The paradox being that the medical and legal dominance precluded the legitimacy of other forms of health care practice being accepted (Chiarella 2002; Street 1992), such as the legitimation of nurses’ expertise.

Further, the way that a hospital was structured, its governance model and bureaucratic traditions, like medical rounds and the fiscal constraints embedded by the health system, was assumed to shape the ways MLWNs viewed their working and professional world. Allen (2004) quoted Neil Small, a Professor of community and primary care in his description of Foucault’s governmentality in hospitals. Small was quoted as saying, ‘such an institution disciplines individuals and exercises surveillance over their lives so that it produces and reinforces actions that are consistent with its views of what is normal in everyday life’ (in Allen 2004:frame 5). Wong Woon Hau (2004:3) linked the current managerialist healthcare policy agenda in Singapore, like that in Australia, to that of Foucault’s technology of governmentality. These kinds of concepts also formed perspectives of the possibility for understanding how MLWNs made sense of and used power to resist/comply/transform at the
margins or at the local levels of interpersonal connections. This interest was along the lines of what Foucault proposed.

At a more local and personalised level, Foucault’s (1988, 1994) concept of technologies of the self was closely linked with self-government which had a complimentary connection to my idea of self-management strategies – the self judging the self and developing strategies to survive and thrive in the work culture and care for oneself. In Foucault’s (1988:19) words, he was interested to understand ‘in the interaction between oneself and others and in the technologies of individual domination, the history of how an individual acts upon himself (sic), in the technologies of self’.

Foucault did not offer suggestions of how to overcome the effects of power (Cheek 2000) or how to self-manage the power relationships (Foucault 1988). As Hartsock (1990:169) emphasised, Foucault ‘calls only for resistance and exposure of the system of power relations’ with no proposition for transformative strategies to either locate or overcome domination. However, Traynor (1997) cast doubts upon the possibility for a new system in which the dominated overturned the dominators. Traynor claimed that ‘no group is able to launch into the project of constructing a new society without, in some sense, creating their own structural oppressions’ (1997:102). What Traynor also highlighted, of interest to me, was his positive expansion of Foucault’s limited analysis of power in his urge to think that:

Subjectivity can be understood as multiple in the sense that the individual can, in one particular subjectivity, undergo oppression while, in another, exercise domination. The nurse, to take one example, can be understood as subject to the immense power exercised by managers, the medical establishment and male epistemology. Simultaneously she or he can be seen as implicated in professional domination over the patient or other healthcare workers, using many of the same technologies of power as other professional groups. (1997:102)

Winch (2005:frame 2) referred to Foucault’s concept of ‘an interiority of subjectivity’ that became a fertile influence in my own interest to understand the
MLWNs’ self-managing strategies. Winch (2005:frame 3), paraphrased Foucault and noted that ‘the self is still a historical and cultural phenomenon created through discourses (including practices), but these now include a domain marked out by the culture of care of the self’. Further, Foucault’s concepts of technologies of the self ‘are the ways in which we understand, develop and govern our thoughts and conduct’ (Winch 2005:frame 3).

Summary of Section 4. Foucault and this Ethnography
With a degree of heightened awareness of the limitations of Foucault’s (1980) power/knowledge construct I found his concepts especially pertinent to my data analysis design. I drew heavily upon his work and that of Lather’s (1991b, c,) feminist postmodern perspectives. On a somewhat similar path to that of Ogle’s (2004:152) ethnographic analysis I found her positioning of Foucault’s concepts of technologies of the self and governmentality also pertinent in relation to notions of mobile subjectivity and agency as these related to the MLWNs’ experiences. In chapter five I explicate the ways that I integrated Lather (1991b) and Foucault’s (1980) perspectives within my data analysis.

As ethnography was integral both to my chosen methodology and method the next section of this chapter extensively develops the various theoretical, ethical and practical considerations I applied to the research.

Section 5. Ethnography as Methodology and Method

Introduction to this section
In this section I explain a number of critically important aspects related to ethnography as both methodology and method. These aspects were of equal significance with those of the philosophical premises of feminism and postmodernism that focused the lens through which I undertook the research. I aim to demonstrate that my research method was embedded in my methodology and that together these complimented my research question, aims and objectives. There was a blurring between ethnographic methodology and method, thus, in this section I discuss, in an integrated manner, both of these perspectives. I incorporate discussion of philosophical ethnographic principles which informed the research. Further, I discuss some methodic aspects that I
actually applied. In the next chapter I present the structured innovative analytic approach that I developed and applied.

The pertinent methodological aspects that differentiated conventional ethnography from critical ethnography are explored in this section. This is because notions from both perspectives were relevant to my investigation of the cultural context in which the MLWNs practised.

In this section, I also clarify issues of validity in relationship to my investigation. I draw upon various scholars’ different proposed criteria for addressing critical qualitative research validity. I also clarify my reasons for applying a slightly modified version of validity criteria proposed by Lather’s (1991b) poststructuralist discourse analysis to my data analysis. Lather indicated her position in relation to postmodernism and poststructuralism, when she stated:

I sometimes use postmodern to mean the larger cultural shifts of a post-industrial, post-colonial era and post-structural to mean the working out of these shifts within the areas of academic theory. I also, however, use the terms interchangeably. This conflation of postmodern with poststructural is not popular with some cultural critics. (1991c:4)

In relation to the process of undertaking the ethnography this section also discusses culture and meaning making, the context for ethnography, and feminist researcher’s responsibilities of reflexivity, intersubjectivity and reciprocity, as well as my ethical role in fostering the MLWNs’ storytelling. Also discussed are the particular methods I applied to data collection and data analysis, inclusive of multiple member checks.

In the first sub-section, below, I establish the different perspectives of traditional ethnography with that of critical ethnography.

Ethnography – Conventional versus Critical
As elucidated in previous sections in this chapter insights from critical social science, feminisms and postmodernisms framed my investigation’s intent to foster reciprocity with the MLWNs as a study ‘with’ and not ‘on’ them. Further,
implicit in the research questions, aims and objectives was my interest to facilitate the uncovering of potential oppressive cultural practice contexts and strategies of resistance to hegemonic discourses; recognising empowering and transformative experiences; and celebrating implicit knowledge each participant had about her work practices. Inherent in the process was my reflexive turn to be an integral participant observer. Feminist politics was implicit in my intention to reveal and critique how the power relations that existed for the MLWNs affected their macro-level practice. Further, my political interest was to foreground the women’s lived experiences as realist exemplars in which valid and valuable knowledge was present. As such, my investigation was situated within a multidimensional critical genre: from a critical ‘activist’ feminist perspective to support the MLWNs ‘breaking the silence’ to ‘unmask’ oppressive ‘institutionalised power relations of domination in the social reality of nursing’ (Glass 1998:124-125 emphasis in original). The investigation was also situated within a postmodern perspective to validate difference and diversity and the partiality and multiplicity of knowledge and truth (Glass 1998; Davis 1998). The best fit for the method to address my inquiry was ethnography – a method within which, as researcher, I could gain a close understanding of the culture within which the women’s knowledge that they consciously or unconsciously took-for-granted could be revealed through our dialogue, my participant observations and reflections and my efforts for mutual interpretation of their lived experiences in their cultural work setting. The emancipatory and political perspectives of critical ethnography complimented my framing of the study within a feminist postmodern ethnographic methodology.

Critical ethnography was predicated upon a transformative liberatory agenda in contrast to traditional ethnography which was ‘framed to describe and interpret cultural realities’ (Street 1992:12; de Laine 1997; Murphy & Dingwall 2001). In contrast, my intent was not to make the MLWNs’ experiences ‘reducible, quantifiable, or able to be made objective’ (Bouma 2000:89). A component of my transformative and emancipatory interest was to engage the women with their data and my insights and understandings as a collaborative reflexive approach to data analysis as a potential way for them to be empowered in the research process (Manias & Street 2001a). In a modest way, my research goal was to open a space within which the nurse participants could engage in
reflective consciousness raising about their personal skills and knowledge in
dealing with the tensions existent between their corporate and professional
responsibilities.

My investigation was intentionally positioned within the framework of a mini-
ethnographic research method (Boyle 1994; Gillis & Jackson 2002; Muecke
1994; Roberts & Taylor 2002a). I chose a localised multi-sited holistic method
(Bouma 2000; Keller 2004; Marcus 1995) informed by perspectives of the
feminists’ oppression narrative and postmodernism in which the individual’s
voice was foregrounded and celebrated as well as being personally integral
within the research (Borbasi, Jackson & Wilkes 2005; Gottschalk 1998). With
the MLWNs I sought to reflexively reveal ‘the complex micro politics of social
Further, from a postmodern perspective, the ethnographer sought to ‘promote
an understanding through recognition, identification, personal experience,
emotion, insight, and communicative formats which engage the reader on
planes other than the rational one alone’ (Gottschalk 1998:214). It was
methodologically informed by Glass and Davis’ (1998, 2004) integrated feminist
postmodern model for nursing research and viewed as historical, partial,
contextual and reflexive (Savage 2000a).

Of critical ethnography de Laine noted:

The critical ethnographer seeks to explore how those who lack autonomy
and coherence of cultural construction of disempowerment [for example
women] respond to their positioning; that they recognise their response
as anything other than individual choice, or even agree that they are
disempowered. (1997:123)

Further, de Laine (1997) differentiated between traditional and critical
ethnographies on the basis of its purpose. The purpose of the conventional
ethnographer was to give ‘outsider’s an insider’s view’; a ‘re-presentation’ of the
cultural world (de Laine 1997:124). Critical ethnography took a ‘reflexive turn’
(Altheide & Johnson 1998:285; Lather 2001b). It subjected ‘the insider’s view to
critical analysis for an understanding of the manifestations of political, social
and material disempowerment (as the ethnographer sees it) . . . which must eventually be completed in political and social action’ (de Laine 1997:124). McLaren (1992:84) claimed critical ethnography as the complex interrelationship between social relations and the researcher’s own social position ‘within the reality that one is attempting to describe’. Further, Manias and Street (2001a:235) asserted that critical ethnography encompassed consideration of social and institutional practices inclusive of the research process ‘as flexible sets of power relationships’.

Of ethnography within a postmodern frame of reference, Lather (2001b:483) noted that ‘confessional tales, authorial self-revelation, multivoicedness and personal narrative, all are contemporary practices of representation designed to move ethnography away from scientificity and the appropriation of others’. However, Van Loon (2001:280 emphasis in original) noted that the writing of ethnography was a discursive practice: ‘writing (graphe) of others (ethne).

Like critical ethnography, in traditional ethnography participant observation, recording of field notes and in-depth conversations were typical multidimensional data collection methods (Atkinson, Coffey, Delamont, Lofland & Lofland, 2001; Denzin & Lincoln 1994; Fenech & Kiger 2005; Reinharz 1992). Inherent in these practices was the investigator who sought to gain thick description, deep insight and understanding of the participants’ view and experiences of their culture and society as they ‘live it’ (Lareau & Shultz in Hodgson 2001:frame 2; de Laine 1997). The ethnographer explored with the cultural group the taken-for-granted understandings of the behaviours, attitudes, beliefs and other aspects of their shared culture. The focus of ethnography was to explain tacit and explicit aspects of a culture, inclusive of ‘unarticulated contextual’ manifestations (Hodgson 2001:frame 2). It also focused upon ‘what is implicit within a culture’ (Gillis & Jackson 2002:204). These notions formed important components for my ethnography.

The shift of focus from description and presentation of the cultural group to that of an emancipatory reflexive turn was the differentiating feature of critical ethnography. Within this context the researcher was ‘part and parcel of the setting, context, and culture he or she is trying to understand and represent’
(Altheide & Johnson 1998:285). These were highly pertinent methodological perspectives that became integral to my research process.

It was, thus, the integration of feminist’s gender focused oppression narrative with affirmative postmodernism notions that framed the critical intent of my ethnography.

The validity of claims emergent from research constitutes a critical component of research in any genre. The following sub-section explores in detail the various validity aspects integral to the ethnography.

**Ethnography and Validity**

Of claims to knowledge derived from the ethnographic process there were a number of validity issues that required consideration to support my choice of ethnography as a suitable method. These issues are developed and clarified in this sub-section.

Hammersley (1992) drew my attention to an important validity issue of any critical research method. He commented that ‘the success or otherwise of a critical theory in bringing about [a person/group’s] enlightenment and emancipation is a crucial, perhaps the crucial, aspect of any assessment of its validity’ (Hammersley 1992:100 emphasis in original). However, Hammersley (1992) was highly sceptical that this instrumental emancipatory validity test was unproblematic. He considered it ‘presupposes that successful practice must be based on correct theoretical assumptions’ (Hammersley 1992:115). His argument was that as a consequence of having applied critical theory the oppressed would recognise their oppression and be emancipated, and that ‘incorrect assumptions must always lead to failure’ (Hammersley 1992:115). Elliott (2005:146) also raised concern of validity by researchers’ claims of emancipatory outcomes.

I acknowledged Hammersley (1992) and Elliott’s (2005) criticisms that ethnography within a critical genre had overt political intent and the risks they raised associated with making overt claims of successful emancipation of the ethnographic cultural group. Hence, the following discussion outlines the key
criteria associated with validity assessment of knowledge claims from different criticalist theorists and ethnographers. Various evaluative criteria as presented below in Table form (Table 29. ‘Examples of Critical Theoretical Validity Criteria’) show a comparative frame against the validity criteria as suggested by Lather (1991b).

Table 29. Examples of Critical Theoretical Validity Criteria.

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<tr>
<th>Pertinent Critical Theorists’ and Ethnographers’</th>
<th>Validity Assessment Criteria of Knowledge Claims</th>
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<tr>
<td>Fay critical social science (1987)</td>
<td>- A theory of false consciousness</td>
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<td>- A theory of crisis</td>
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<td>- A theory of education</td>
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<td>- A theory of transformative action.</td>
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<td>Lather feminist poststructuralist (1991b)</td>
<td>- How does a feminist perspective inform each exemplar?</td>
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<td>- How does each reinscribe what it is resisting – how does it deal with power relations between the researcher and the researched, for example?</td>
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<td>- How does each deal with issues of objectivity/subjectivity?</td>
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<td>- Does each assume found or constructed worlds?</td>
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<td>- How are the exemplars influenced by unspoken norms and values?</td>
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<td>- What is left out?</td>
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<td>- How does each resist and/or interrupt present power arrangements?</td>
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<td>- To what extent does each exemplar expand your sense of the possibilities of postpositivist empirical work in education?</td>
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<td>Parsons postmodern (1995)</td>
<td>- Credibility</td>
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<td>- Adequacy</td>
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<td>- Transferability</td>
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<td>- Political praxis</td>
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<td>- Multivoiced texts</td>
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<td>- Dialogues with subjects</td>
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<td>Wainwright critical ethnography (1997)</td>
<td>- Reflexivity</td>
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<td>- Trust</td>
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<td>- Interviews focused but open-ended – getting beneath the surface of everyday life to reveal the extent to which subjects are constituted by ideology or discourse</td>
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<tr>
<td>Pertinent Critical Theorists’ and Ethnographers’ Validity Assessment Criteria of Knowledge Claims</td>
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<td>• Deep analysis – oscillation between data &amp; social critique</td>
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<td>• Informant quotes</td>
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<td>• Writing up as part of analytical process</td>
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<td>• Resonance with reader</td>
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<td>Altheide and Johnson interpretive ethnography (1998)</td>
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<td>• Accounts of interaction among context</td>
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<td>• Evaluation:</td>
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<td>• Credibility</td>
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<td>• Relevance</td>
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<td>• Importance of topic</td>
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<td>• Attention to:</td>
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<td>• Member check</td>
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<td>• Locate the author’s voice</td>
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<td>• Entre - organizational and individual</td>
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<td>• Approach and self-presentation</td>
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<td>• Trust and rapport</td>
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<td>• Role and way of fitting in</td>
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<td>• Types and varieties of data</td>
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<td>• Data coding and organization</td>
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<td>• Data demonstration and analytic use</td>
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<td>• Narrative report</td>
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<td>Kincheloe &amp; McLaren critical ethnography (2000)</td>
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<td>• Experience</td>
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<td>Sheriff critical ethnography (2001)</td>
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<td>• Reflexivity</td>
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<td>• Power relations</td>
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<td>• Establishment of rapport in the field</td>
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<td>Carspecken critical ethnography (2003)</td>
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<td>• Disruption of traditional power of researcher – equal negotiations with those involved</td>
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I especially applied Lather’s (1991b) feminist poststructuralist/postmodern research criteria to help me be confident in the validity of my data analysis. As previously noted, Lather often interchangeably applied the terms postmodern and poststructural. My research methodology applied perspectives particularly drawn from literature and research that used the term postmodern, as
discussed in this chapter. To indicate one of the premises of poststructuralism that I appropriated, along with Lather’s (1991b) notions, was a clarification made by Francis (2000). Francis (2000) described that structuralists’ argued that all storylines have a similar and known basis. On the other hand, poststructuralists’ challenged this universal notion. Poststructuralists argued that being immersed in the language meant objectivity was not possible. Further, the perspective was that there could be multiple different interpretations of language and that ‘dominant storylines or claims to truth can be “deconstructed” and dismantled’ (Francis 2000:23 footnote 3 emphasis in original). The notions that MLWNs’ narratives, and other ethnographic data as text, could be deconstructed and dismantled formed important aspects of my analytic processes.

Lather’s (1993:674) research focus was predominantly on valorising practice over theory. Lather (1993:674) questioned ‘what might open-ended and context sensitive validity criteria look like?’ This was contrasted to the limiting and disciplinary criteria of foundational positivist research. Although her propositions were densely written, she opened the postmodernist possibility to reframe validity ‘as multiple, partial, endlessly deferred’ (Lather 1993). This stance, thereby, resisted practices of the past’s closure on truth. Instead, she moved the possibility for validity associated with social inquiry to a different space. This focus was toward ‘constructed visibility of the practices of methodology . . . a site that “gives to be seen” the unthought in our thought’ (Lather 1993:676 emphasis in original). As part of her anti-authorial practices she articulated that the poststructural move, and thus also for postmodernists, ‘is to foreground the difficulties involved in representing the social rather than repressing them in pursuit of an unrealized ideal’ (Lather 1993:677). These notions were significant in the way that I considered how to analyse and present the women’s experiences as a method to valorise their insights and knowledges. I also fully acknowledged that the revealed insights were not summative of fixed truths. It was also a troubling position to know that my approach would be but one of many, partial, fragmented and incomplete possibilities.

Lather’s (1991b:30) set of research validity questions brought a sense of specificity for keeping a postmodern feminist focus on the research process.
Her perspective included critically challenging issues of patriarchal oppression, resistance to the dominant discourse, objectivity/subjectivity of the participant, taken-for-granted values, norms and exclusions, and the relationship between researched and researcher (Lather 1991b). It was these criteria that I embedded within my data analysis process of each MLWN’s narratives and detail in chapter five.

Lather’s (1991b:30) set of validity criteria is presented below in Table 30. ‘Feminist Postmodern Analytic and Validity Criteria (Lather 1991b:30)’. The adaptation I made involved altering Lather’s (1991b) use of the term ‘exemplar’ to that of MLWN. My aim was to locate my analytic thinking with a real person, that of each MLWN.

Table 30. Feminist Postmodern Analytic and Validity Criteria (Lather 1991b:30)

<table>
<thead>
<tr>
<th>Feminist Postmodern Analytic and Validity Criteria (Lather 1991b:30)</th>
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<tbody>
<tr>
<td>How does a feminist perspective inform each exemplar?</td>
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<tr>
<td>How does each reinscribe what it is resisting – how does it deal with power relations between the researcher and the researched, for example?</td>
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<tr>
<td>How does each deal with issues of objectivity/subjectivity?</td>
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<tr>
<td>Does each assume found or constructed worlds?</td>
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<tr>
<td>How are the exemplars influenced by unspoken norms and values?</td>
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<tr>
<td>What is left out?</td>
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<tr>
<td>How does each resist and/or interrupt present power arrangements?</td>
</tr>
<tr>
<td>To what extent does each exemplar expand your sense of the possibilities of postpositivist empirical work in education?</td>
</tr>
</tbody>
</table>

What follows is an overview of other critical and postmodern theorists’ suggestions to assess the validity of qualitative and ethnographic work. These suggestions were collectively important and formed a self-assessment frame of my research process. These alternate ethnographic validity suggestions were summarised, above, in Table 29. Examples of Critical Theoretical Validity Criteria’.

Fay (1987:31-32) proposed a detailed set of criteria against which validity of a critical social science ethnographic theory could be assessed. His validity criteria focused upon critique of the emergent social science thesis based upon several related notions: false consciousness; a theory of crisis; a theory of education; and a theory of transformative action. In other words, each of these criteria needed to be satisfied to validate the thesis. I considered this approach
would not have satisfactorily addressed my research question, aims and objectives.

The legitimacy of undertaking qualitative research with a postmodern approach, posed by Parsons (1995), required different criteria to that of traditionally established quantitative criteria. For postmodern research Parsons (1995:24) identified a variety of emergent alternative criteria: ‘credibility, adequacy, confirmability, verisimilitude, emotionality, and personal responsibility, an ethic of caring, transferability, dependability, political praxis, multivoiced texts, and dialogues with subjects’. These criteria, if applied, would also not have provided depth of validity I believed was needed for my ethnography.

Altheide and Johnson (1998:284 emphasis in original) identified the challenge for any interpretive methodology in their question: ‘How should these be judged by readers who share the perspective that how knowledge is acquired, organized, and interpreted is relevant to what the claims are?’ Altheide and Johnson (1998:292) suggested an evaluative approach to ethnography within the province of ‘analytic realism’ as ‘the process by which the ethnography occurred must be clearly delineated, including accounts of the interactions among context, researcher, methods, setting, and actors’. They recommended applying an ethnographic ethical frame to evaluating the relevance of contemporary ethnography which included ‘plausibility, credibility, relevance, and importance of the topic’ (Altheide & Johnson 1998:293). There responsibility for the researcher was to ‘obtain the members’ perspectives on the social reality of the observed setting’. It was also important that the researcher ‘show where the author’s voice is located in relation to these’ (Altheide & Johnson 1998:293). These kinds of criteria were important for me to take into account. However, these criteria were insufficient as a basis to support validity of my ethnographic process and emergent insights.

Kinanchlo and McLaren (2000) noted the need for the critical ethnographer to be transparent about: emphasising experience, subjectivity, reflexivity, and dialogical understanding. These theorists (Kinanchlo & McLaren 2000:303) drew from Slaughter’s (1989) challenge in that the critical postmodernist researcher needed to ‘construct their perception of the world anew, not just in
random ways but in a manner that undermines what appears natural, that opens to question what appears obvious’. In respect to ethnography and my feminist emancipatory research interest, Kincheloe and McLaren’s (2000) perspective was relevant. They highlighted that the source of emancipatory action in the research field required the ethnographer ‘to expose the contradictions of the world of appearances accepted by the dominant culture as natural and inviolable’ (Kincheloe & McLaren’s 2000:292). They proposed that such techniques would reveal issues of inequality, injustice, and exploitation.

Of contemporary critical ethnography and validity Sherif (2001:436) also noted its ‘emphasis on reflexivity, power relations, and the establishment of rapport in the field’. These validity notions were also pertinent but insufficient to my research approach.

Carspecken (2003:frame 58) asserted that ‘critical ethnography must make the effort to disrupt the traditional power of the researcher’. He drew attention to the researcher’s responsibility to demonstrate equitable relationships in all aspects of the ethnography with those affected by the research. This validity feature was similar to feminist research method and, thus, was pertinent but limited as a scope of validity features.

Throughout the ethnographic process I consciously kept in mind the various ‘validity’ issues as discussed above.

In the next sub-section I further discuss notions of culture and meaning making as these pertained specifically to the ethnography.

**Culture and Meaning Making**

Schneider, Elliott, LoBiondo-Wood, and Haber (2003:180), along with other feminist and postmodern feminists as discussed earlier in this chapter, affirmed for me the culture that I was interested to interrogate. My cultural focus was one in which ‘knowledge [was] learned, shared and understood by each member of the group so that their interactions and behaviours can be interpreted and understood by its members’. Ethnography would allow me, as the research instrument and participant observer, to be immersed in the MLWNs’ culture.
(Fetterman 1998). This research practice was a fundamental criterion in order to develop a deep understanding of the way of ‘life’ as experienced by the participants – the emic perspective. This practice would permit me to more fully focus on participant’s meanings and interpretations of their lived experience. It would also permit me to identify and understand the taken-for-granted constructs of the context within which they practised (Walcott, 1994).

The qualitative research activities related to meaning making included description, analysis and interpretation. Savage (2000b:1494) drew from Walcott (1994:12) to note that of description it was asking ‘What is going on here?’ Of analysis it was about reaching an understanding about meaning and interpretation as ‘What is to be made of it all?’ These questions were integral in my reflexive data analysis process.

Ethnography has had a long history as a research method. Bouma (2000) made reference to Herodotus, an ancient Greek, who was an ethnographer. Herodotus recorded variations in the cultures to which he was exposed. However, Savage (2003:58 emphasis in original) drew from Grosz’s (1994) comments that the ancient Greeks assumed that ‘what is “objectively” observed will have greater epistemological value than data gathered by other senses’. Of this disconnected and authorial perspective Savage (2003:58) criticised the empiricists’ primacy of ‘ocularcentric’ ways of knowing. This critique was similar to Foucault’s (1973) criticism of the sovereignty of the gaze in science. For Savage (2003:59) ‘the lived body is not just one thing in the world but a way in which the world comes to be’. Using the ‘habitus’ concepts from Bourdieu (1990:53) Savage (2003:59) brought my attention to important considerations pertinent during the ethnography that contributed to meaning making and understanding the MLWNs’ localised knowledge. Savage (2003) highlighted that the insignificant details of every-day life inscribe the fundamental principles and values of culture.

Savage (2000c) further highlighted the different ways that participant observation, as a principal feature of ethnography, had been viewed as both a method and methodology. From a methodological perspective, participant observation was one form of understanding human existence in its various
sensory forms, inclusive of knowledge derived from non-linguistic experience (Savage 2000c). I was interested to integrate a multiplicity of sense-forms to facilitate meaning-making.

The concepts and perspectives of researcher presence in the ethnographic field, as noted here, confronted the long-held quantitative evaluative criteria of research objectivity. Objectivity was a rejected phenomenon within feminism and postmodernism. The Cartesian stance of quantitative and most traditional qualitative researchers was that of being an uninvolved observer, ‘unaffected by and external to the interpretive process’ (Schwandt 2000:194). This stance contrasted markedly from the ethnographer who aligned with philosophical hermeneutics influenced by Heidegger (Schwandt 2000). Cohen and Omery (1994:146) portrayed Heidegger’s meaning of hermeneutics as ‘the interpretive method by which one goes beyond mere description of what is manifest and tries to uncover hidden meanings by anticipatory devices’. Philosophical hermeneutics dismissed the epistemological assumption that in the act of interpreting the researcher can control and put aside their ‘traditions and associated prejudgments that shape our efforts to understand’ (Schwandt 2000:194-195). On the contrary, Schwandt (2000) asserted, understanding required the engagement of one’s biases and those biases and prejudices needed to be tested in the dialogical encounter. Inherent in that dialogue was a process of meaning making which is not discovered but rather a negotiated act. These features of philosophical hermeneutics were pertinent to me because of the links with feminist and postmodernist principles. Philosophical hermeneutics focused on ‘understanding as a kind of moral-political knowledge that is at once embodied, engaged (and hence “interested”), and concerned with practical choice’ (Schwandt 2000:196 emphasis in original). The ethical implications related to researcher bias, as discussed here, were particularly important considerations. Later in this section, as well as in chapter five, I make explicit the ways that I reflexively attended to my researcher biases.

To further support my choice to have used ethnography was Lather’s (1991c) postmodern feminist position of culture. She viewed culture ‘as neither fixed nor finite but as dynamic, expansive and intrinsically shaped by power and the struggle against it is to occupy a very different position in this “crisis” of authority
over what is to count as legitimate knowledge’ (Lather 1991c:xvi emphasis in original). Her point was to shift the notion of a singular, fixed ‘subjectivity’ (Lather 1991c:xix) to that of one being a mobile subject. Lather’s (1991c) perspective offered me a deeper understanding of the legitimate possibilities for women to form a sense of themselves that was not set in concrete. In addition, her views clarified that women’s perspective of themselves and the knowledge they embraced could be different at different times and contexts. Further, Ogle’s (2004:168) description of culture was pertinent to my research in that culture ‘is not a static object of analysis, but a multiplicity of negotiated realities within historically contextualized and contested communicative processes’.

Ethnography was synonymous with the researcher being deeply immersed in the culture of the participants. Understanding the culture in which women live, like that of the MLWNs, had the possibility for revealing legitimate meaningful knowledge. Further to these possibilities was that feminist ethnographers sought to establish openly subjective, transparent and trusting relationships with the cultural group. Being in the context with participants was a critical feminist research practice for the sociopolitical production of knowledge. The concept of context is discussed in the following sub-section.

**Context**
The ethnographic research process and my philosophical framework were especially suitable and applicable to my research question, aim and objectives. My interest was to explore, critique, and reveal epistemological and ontological perspectives of individual participant’s knowledge through their behaviours, words, silences, meanings and stories of their lived experiences within their cultural work context. The investigative context aimed to support participants to tell and explore their stories and to provide an environment in which they could reconstruct their cultural taken-for-granted understandings and relationships in the world.

It was assumed that the MLWNs were confident and comfortable with an ethnographic approach for the research project because nursing research had been an integral component of professional practice in WA since the mid1980s. Further, Goldstein (1994:42) drew my attention to the situation that my
ethnographic inquiry had a ‘natural affinity’ with the nature of nursing practice. Goldstein’s (1994:46) study with social workers noted that health professionals ‘do ethnography when they strive to know and understand their clients, not according to some grand theory or universal framework’. However, I was also cognisant that the MLWNs may not be familiar with a feminist postmodern methodology and that this most likely needed to be explained.

Of the production of knowledge, Sandra Harding’s (1993:65) exploration of feminist standpoint theory posited that knowledge was ‘socially situated’ and became knowledge ‘when it is socially legitimated’ (Harding 1993:65). For Harding, more specifically, thought should start from ‘marginalized lives’, such as women’s lives, rather than from the position of those ‘at the centre who make policies and engage in social practices that shape marginal lives’ (Harding 1993:54). In order to take advantage of Harding’s proposal, being in the world of the MLWNs by using ethnography as the research method was viewed to be appropriate for this study. Her assertions also supported my research interest to publicly valorise and legitimate the emergent insights of the lived experiences of MLWNs. Nurses in public hospitals practice within a community of nurses, other health professionals and many other different local cultural groups. My own experience in these settings confirmed much of the concepts noted by Code (1991), Harding (1993) and Horsfall (1996). Their notions strengthened my assumptions that nurses’ knowledge was more legitimated within the localised community of nurses but less so within broader health care professionals’ community. The notions put forward by these feminist scholars became fertile considerations within the cultural context of the project.

Savage (2003:53) advocated for nursing researchers to become participative observers to enhance their understanding of ‘experiential knowledge or embodied intelligence’. For Savage (2003:54) participative observation was a strategy for ‘finding ways of articulating the non-measurable elements of quality care, such as embodied intelligence, and the ambiguities of practice’ which drew upon the subjective and senses experience. It was about standing in the other’s shoes in order to ‘experience the world from the other’s perspective’ (Savage 2003:55). Although I appreciated the notion of placing oneself in another’s shoes, this notion did not fit comfortably with me. Rather, my interest
was to keep in my own shoes as a participant observer, integral to the research, but to bring my knowledge and critical intent into the research context from my multiplicities of experiences as a woman, clinician nurse, middle-level academic and manager and executive manager. As a reflexive and active participant observer this position provided me with a unique and opportune space to deeply understand the embodied experience of the cultural context of women nurse professionals working in middle-level roles within patriarchal systems.

Fay (1987) espoused, from his critical social science perspective, that it was within their community or cultural group that the individual formed a sense of oneself. He took this cultural perspective further, by claiming potential emancipatory capacity to ‘learn how to reflect on and change their behaviour, ideas, desires, and principles’ Fay (1987:51). A person’s self-understanding, in Fay’s (1987) view, was thus constituted by the shared understandings of the culture and community, like that of a MLWN within her culture of the hospital, with an ability to change through the process of self-reflection. Fay’s (1987) view of self-understanding and ability to transform was, for me, too simplistic and an unachievable possibility especially given the plethora of research that affirmed the medically dominant hospital culture.

For the social group to gain self understanding the critical social science researcher was like an educational revolutionist. They aimed to facilitate an environment within which individuals stripped away their false knowledge and hidden meanings and came to see for themselves the contradictions, frustrations and deficiencies they actually were experiencing (Fay 1987:99). Although my strong tendency was toward an educative change model I rejected a ‘revolutionist’ authoritative approach to the ethnography. My feminist postmodern role, in contrast, sought to open up a safe and non-manipulative dialogic space. As Wittmann-Price (2004:440 emphasis in original) noted, ‘the “growth of voice” was a feminist metaphor for empowerment, and the term “silence” has come to symbolize oppression’. Within this context my interest was that participants could speak for themselves and reflect upon alternative options to oppressive or unsatisfying conditions and how these options could be achieved. However, I appreciated Fay’s (1987) view that it was from the emic perspective. It was not that of the investigator’s etic view that the impetus for
change may, however, only occur with those who see themselves as marginalised and prepared to personally take on the challenge to be liberated. In other words, it was understood that not every woman who engaged in reflexive dialogue would achieve consciousness raising or become empowered (Glass 2000).

From a feminist second wave perspective, within the oppression narrative, Lather (1991b) drew my attention to the importance of context to the research methodology. Of feminist research context Lather (1991b:18) noted it was a site for ‘generating and refining of more interactive, contextualised methods in the search for pattern and meaning rather than for prediction and control’. In the ethnographic process with the MLWNs Lather’s (1991a:153) claim was pertinent to the way I sought to view the cultural context in that it ‘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, partial’. The experiential features for MLWNs practicing within a multiplicity of power relations as well as the multiple discourses that politically interweaved in their ways of being and their own views of their subjectivity (Crowe 1998) were partially the complex contextual web of my interest.

My ethnography sought to understand the dynamics of each MLWN’s interpersonal relationships in respect to her nurse-nurse and nurse-other health professional relationships and in no way was about measuring, judging or reporting on her practice or personhood. The MLWNs potential taken-for-granted experiences could best be understood by my presence and immersion in the cultural context of their work. My interest was toward the stories they told me about their practices and not that of aspects of their direct patient care or of private staff conversations or interviews. I anticipated that during participant observation our informal conversations would reveal issues that would further inform our in-depth critical conversation.

In order to enhance opportunities for the MLWNs to reveal their experiences the feminist research feature of reflexivity was integral to my researcher role, as discussed below.
Reflexivity

Reflective practice and reflexivity skills were emerging as critically important for any nurse, as highlighted by Taylor (2000) and further by Freshwater’s (2002) assertions of practicing nurses. Freshwater (2002:x) claimed that nurses were ‘now encouraged to develop close relationships with patients so that they can understand the meaning their illness has for them and to use this knowledge to jointly plan individually tailored care’. In the context of nursing research Clarke (2006) highlighted, as she described of her biographical qualitative study, that harmful effects upon research participants can be minimised by the researcher’s reflexive skills and approach.

Parsons (1995:24) noted that reflexivity was first explained as ‘the relationship between consciousness and reflexive moments in thought mediated by language’. Of reflexivity Gergen and Gergen’s (2000:1027 emphasis in original) description related to the researcher who ‘relinquishes the “God’s-eye-view” and revealed his or her work as historically, culturally and personally situated’. Further, they clarified the meaning of reflexivity in which investigators:

Seek ways of demonstrating to their audiences their historical and geographical situatedness, their personal investments in the research, various biases they bring to their work, their surprises and ‘undoings’ in the process of the research endeavor, the ways in which their choices of literary tropes lend rhetorical force to the research report, and/or the ways in which they have avoided or suppressed certain points of view. (Gergen & Gergen 2000:1027 emphasis in original)

Campbell and Wasco (2000) were in agreement with Taylor and White’s (2000) explanation of reflexivity as meaning active cognitive and emotional engagement in the research process. Also, by the researcher examining and making personally explicit the various kinds of knowledge one used to ‘make sense of events and situations they confront’ and was not simply a process of ‘benign introspection’ (Taylor & White 2000:6).

Wainwright’s (1997:frame 7) argument that the purpose of researcher reflexivity ‘is not to produce an objective or value-free account of the phenomenon . . . but
rather a personal strategy by which the researcher can manage the analytical oscillation between observation and theory in a way that is valid to him or herself. Although I was not seeking to create a theory, my use of reflexivity aimed to challenge my own trustworthiness in each stage of the research process ‘from establishing relations in the field to writing up the conclusions’ (Wainwright 1997:frame 7). Greenwood (1998) and Foster and Greenwood (1998) asserted that self-reflective skills were directly linked to learning, whereas Gottschalk (1998) noted it could also act as a self-monitoring and an emancipatory practice.

In responding to the feminist scholarship of reflexivity I had, throughout the ethnographic process and this thesis, openly incorporated my experiences, assumptions, complexity of emotions, critical reflections of my researcher technique, and identified my transformative liberating changes relevant to the ethnography. Clarke (2006) made similar comments to that of Keller (2004:222) that not only supported the inclusion of personal accounts by the researcher but he also argued for ‘a more thoughtful, purposeful, and reasoned inclusion of it’ so that there was not a detraction from the goals of the ethnography. To this consideration I was acutely sensitive that the thesis was not my terrain for self-healing, or disclosure of unnecessary personal or professional detail. However, of my reflexivity throughout the research I concurred with Struebert (1995:92) who asserted that reflexivity ‘leads to fuller understanding of the dynamics of particular phenomena and relationships found within cultures’. In addition to these notions, Williams (1993) asserted that the researcher’s reflexivity of self included the primacy of experience that impacted upon the research process and outcomes.

On a more cautionary note, however, was Alsup’s (2004) warning of the way the researcher writes her personal revelations in one’s research. She explicated the risks associated with writing as a unitary subjectivity as being ‘rigid in her relationship with participants or in her analysis of research participants or situations, self-obsessed, or only seeking some sort of voyeuristic exposure’ (Alsup 2004:228). Such an approach risked being accused of bias. In acknowledging that we function within a multiplicity of subjectivities, or ‘non-unitary’ (Alsup 2004:228) subjectivities, Alsup (2004:235) suggested that as a
purposeful stance by the researcher it ‘may increase the perception of the intellectual rigor of qualitative research and researcher ethos’. Harding (1997:165) asserted the necessity for inclusion of the feminist researcher’s beliefs and behaviours as relevant data that must also be ‘open to critical scrutiny’.

In an embracing and ethical perspective of reflexivity, Glass and Davis’ (1998) referred to the importance of one’s own integrity as a researcher. Of the researcher responsibility, they identified that ‘one’s responsibility to act should be guided by the responsibility to otherness and that such responsibility intricately involves validation of difference, which in turn results in a celebration of common humanity’ (Glass & Davis 1998:50).

Taking the practice of reflexivity as an intrapersonal practice to that of an interwomen process are the notions of intersubjectivity and reciprocity within a feminist perspective, as the following discussion explores.

**Intersubjectivity and Reciprocity**

My educational studies during the 1970s drew me to the text by Bowen and Hobson (1974) in which they presented selected writings of Dewey, an educational philosopher. Dewey made a profound impact on my appreciation of the reflexivity and reciprocity between teaching and learning as two-way processes. From Dewey’s 1899 publication of School and Society (in Bowen & Hobson 1974) his reference to the value of reflective thinking, and thus the process by which reflexivity and reciprocity occurred, was made explicit by Dewey. Dewey stated that, ‘the material of thinking is not thoughts, but actions, facts, events, and the relations of things’ (in Bowen & Hobson 1974:191).

Further, of feminist intersubjectivity, Campbell and Wasco (2000:frame 13) claimed that feminist research was explicitly ‘personal and political’. For these scholars, feminist scholarship made no apologies for its emotional connectedness with feminist research. Aligning with Campbell and Wasco’s (2000) comments, my personal and professional connection with the MLWNs throughout the ethnography was integral to my feminist interest to foster the research process as an empowering component of the methodology and
method, of equal, if not, more relevance to that of the research outcomes. Our intersubjective connections formed ‘a setting for consciousness raising and [potential] social change’ (Campbell & Wasco 2000:frame 13).

Carspecken (2003:frame 58) described intersubjectivity as ‘taking the position of others with respect to meaningful acts’ and as related to ‘the inferences we tacitly make when hearing utterances’. The core process of explication was involved in theorising about intersubjectivity in that it was ‘moving from implicit understandings towards explicit articulations’ (Carspecken 2003:frame 53). In respect to the role of the critical ethnographer’s etic and/or perspectives Carspecken in an earlier text asserted that:

Understanding occurs not through occupying one position or the other but rather in learning the cultural movement between them. Understanding is intersubjective, not subjective or objective. (1996:189)

The reflexive turn, as noted earlier of critical ethnography, inherently incorporated the practice of intersubjectivity and reciprocity. The blurring boundaries between the researched and the researcher, noted by Olesen (2000), was a juncture at which traditional qualitative feminist researchers were highly critical of the risks that scientific validity and reliability would be compromised. Feminist researchers brought intersubjectivity between researchers and researched into the foreground (Cole 1995).

Of intersubjectivity, Glass (2000) confirmed that in feminist research the dialogue between investigator and participants aimed to be a mutually consciousness raising process within a trusting relationship and from which experiential knowledge emerged. Through this inter-personal process Glass (2000:357) further claimed it fostered ‘self-awareness, self-growth and subsequent motivation for social change’. Freire’s (in Fay 1987:107) critical social science problem-posing reflective dialogue was also pertinent to how I approached each participant. Reflexive intersubjective dialogue supported the unfolding of women’s experiential knowledge and their opportunity to reveal or reconstruct their own empowering, emancipatory and transformative strategies. Walter, Glass and Davis (2001:270) noted that intersubjectivity was another
research strategy to equalise the power relations between researchers and participants’.

Walter, Glass and Davis (2001) further referred to intersubjectivity in relation to the feminist researcher as a research participant. This active researcher practice had the possibility of incorporating strong epistemological and ontological links of intersubjectivity as a way that feminist researchers ‘demonstrate that they live their research beliefs’ (Walter, Glass & Davis 2001:268). They also described intersubjectivity as referring to ‘the researcher as subject in a reciprocal, dialectical and dialogical co-researcher relationship’ (Walter, Glass & Davis 2001:268). Walter Glass and Davis (2001:268) proposed that as a participant/researcher there was enhanced awareness of the realities of the research and which reduced the introduction of new forms of domination by way of the research process. Ten years earlier, Code (1991) also asserted similar benefits of intersubjectivity research practices. Code (1991:132) linked a method of constructing knowledge with that of intersubjective processes.

Code (1991), like Harding (1993), did not advocate the dismissal of the scientific approaches to knowledge discovery, rather they fostered the need for feminist critique of what was excluded or suppressed from scientific work and to challenge its underlying unstated assumptions, methodological and ideological frameworks. In contrast to scientific methodology, Code’s (1991) consciousness raising methodology for women, as a knowledge producing method, was integral to her second-personhood model. Code’s (1991:220) model embraced trusting intersubjective relationships which ‘can develop into the power women need to reposition themselves in relation to authority and expertise.’ For Code (1991:292), these kinds of ‘positionality’ were ‘sites of emancipatory dialogue’. Inherent in her second-personhood model were strategies ‘that do not require disadvantaged women to emulate the advantaged, but they make available new beginnings, from where women are’ (Code 1991:292 emphasis in original). What this meant was that difference within and among women should be valued and that universalism and gender-neutrality should be rejected (Code 1991). Code (1991:121) structured her feminist theory upon her perspective that humans were ‘second person’ beings. This conception of subjectivity
'represent[s] the production of knowledge as a communal, often cooperative though sometimes competitive, activity' and not 'monological pronouncements that autonomous reasoners presume to make' (Code 1991:121). Within my ethnographic setting, informed by feminist postmodernism, opportunities did arise to take advantage of Code’s assertions.

Glass (1998, drawing from Hall & Stevens 1991), Horsfall (1996), Speedy (1991), and Street (1992), strongly affirmed the value to nurse researchers who undertook women-focused research with a purpose to uncover oppression and support transformative change with them. To be effective, these scholars strongly asserted that the feminist researcher must take into account the three basic tenets of feminism: women are patriarchally oppressed, the personal is political, and women’s reality emerges via consciousness-raising processes, and that intersubjectivity was crucial to this research process. One of my research assumptions was that the social and political context of nursing, especially in the middle-level positions within the public hospital system, stifled the transformative possibilities for many nurses. Thus, these feminist tenets and collaborative meaning-making practices were necessarily embedded in my ethnographic processes.

Dialogic reciprocity, as noted in philosophical hermeneutics also influenced me, by confirming that in the act of dialogue in which understanding was the primary goal, there is also interpretation which ‘is a very condition of being human’ (Schwandt 2000:194 emphasis in original). Meaning is ‘produced’, not ‘reproduced’ (Schwandt 2000:195 emphasis in original). This notion contrasted with the instrumentalist researcher and other interpretive investigators. These underpinning research theoretical perspectives privileged the researcher as the principal interpreter of meaning and as manipulator (deliberately or otherwise) of the participant’s change. Anderson (1991) had similar ideas to that of Schwandt (2000:196) who drew from Gadamer’s work (1981) to highlight that the process of successful understanding meant ‘growth in inner awareness, which as a new experience enters into the texture or our own mental experience’. The implication of this process was a transformation in ourselves (Schwandt 2000). This kind of transparently shared dialogue and non-authoritative privileging by the researcher aimed to mutually minimise
resistance to personal consciousness awareness, and maximise empowerment and evoke possible change through reciprocity.

Oakley (1988:41), a prominent feminist researcher, claimed the investigator must ‘invest his or her own personal identity in the relationship’, which also included biases and opinions. Of the feminist research process Johnson (1992:219), drawing from Webb (1984), supported the need for the investigator to be a person, not a ‘dispassionate scientist’ and to ‘view the experience as a social exchange’.

The feminist researcher’s use of intersubjectivity was also commonly in the form of reflective journalling. Reflective journalling formed one of the multiple methods I used as part of data collection. I concurred with Glass’ assertions that:

Journalling provides opportunities for feminist researchers to immerse themselves considerably in their research. In particular, journalling usually encompasses the feminist researcher’s own concerns and issues about doing as well as participating in the research. (2000:370 emphasis in original)

Inherent in the notions of reflexivity, intersubjectivity and reciprocity, as feminist research practices, were ethical considerations related to the role and relationship the researcher created with her participants. Ethical considerations which were pertinent to my ethnography are explored in detail below.

**Author’s Ethical Role in Fostering Storytelling**

The emancipatory potential for this ethnography was critically related to the position I established with the MLWNs. This anticipated location aligned with my feminist aim to centre the MLWNs’ voices. Interconnected to foregrounding the women nurses’ voices as the authentic knowers was the method of how to do this without speaking for them, as highlighted by many feminists, like Lather (1991c). Inherent within these feminist perspectives were other feminist ethical researcher practices; trust, presence and safety to speak, non-hierarchical
relationships, data ownership, and research writing. In this sub-section these aspects of the ethnography are discussed.

**Trust, Presence and Safety to Speak**

From the comments raised and discussed above it was apparent that the depth of participant disclosure was dependent on the level of trust established between me, as researcher, and the MLWN. There was not just my communication style but also a number of personal ways of being: sensitive, ethical and enabling, which aimed to establish and maintain trust and to provide support to the participants if the situation became stressful. Lemert’s (1997:13) words were pertinent in that, ‘when trust is broken, the truth is beyond even scientific rigor to restore’.

From a feminist postmodern perspective, the ethnographer was required to be visible, known, and embodied as a ‘real, historical individual with concrete, specific desires and interests’ (Cole 1995:195). It was, therefore, important for me to be real at the same time as focusing upon reciprocity methods that would foster the MLWNs to tell their stories of their experiences; those that the MLWNs viewed as empowering, transformative and disempowering; and to engage them in reflective critical thinking of aspects of their working life that they took for granted.

Overtly maintaining respect and integrity with each MLWN was also clearly as important as ensuring ‘not to intrude into areas that the narrator has chosen to hold back’ (Anderson & Jack 1991:25). As Glass (2001c:5, 2003a) found in her ethnography with women nurse academics ‘an integral component of understanding the context and the culture was the explicit use of mutual storytelling in emotionally safe environments’. In addition to these kinds of ethnographer roles the disclosure by me as the ethnographer of my assumptions, as discussed in earlier sub-sections, in exploring experiences aligned with feminist methodology of fostering participants’ trust (Williams 1993; Johnson 1992).

Carberry (2001:83) noted that, ‘in the telling, the story-teller becomes part of the story and, like the listeners, can be embraced and changed by its meaning’. 
Banks-Wallace (1998:17) drew from Bacon’s comments of 1933, in his reference to the history of storytelling as therapeutically beneficial in nursing. Glass, Taylor, Stirling and McFarlane (1999:162) also affirmed from their research that story-telling had positive therapeutic influences for both patients and nurses in their study designed to investigate ‘what are dying patients’ perceptions of the nature and effects of palliative nursing care?’ As Cosgrove and McHugh (2000:frame 6), drawing from Belenky, Clinchy, Goldberg, and Tarule (1986), reaffirmed that for women, in the telling of their experience, the feminist metaphor of voice was ‘used by women to describe their epistemological positions’, inclusive of terms like: ‘speaking up; speaking out; being silenced; not being heard; really listening; feeling deaf and dumb; and saying what you mean’ and was a source of empowerment. These notions were supported by a number of feminist scholars and researcher and linked the notions of giving women voice with consciousness-raising process (Campbell & Wasco 2000; Glass 2003a, b; Phillips 1997).

In a similar manner, the term ‘unsaid’ was a feminist term created by Glass (2003b:189) in relationship to research women participants who, in the safe trusting reflexive relationship with a feminist ethnographer, were able to speak out for the first time of destructive experiences where they had not been heard, did not talk, sensed being invisible, were excluded and isolated themselves. It also referred to sub-texts of what the ethnographer observed that was not verbalized. The safe environment was also one in which the woman’s identity was protected. Protecting participants’ identity extended into the writing of the thesis. I was acutely aware that each MLWN would be able to self-identify. One method I applied to protect their identity was a third round member check with each MLWN to affirm that my selection of their respective data did not identify them.

Within the cultural context of the ethnographic world of nursing practice I was interested to hear the multiplicity of MLWNs’ voices, the personal and professional aspects of their lives which was previously undisclosed and unacknowledged ‘unsaid’ (Glass 2003b:189). I was interested to foster the MLWNs ‘making the invisible visible, bringing the margin to the center (Reinharz 1992:248) of the meanings they made of their lived experience. My
interest was to explore their knowledges and insights of their practice that were taken-for-granted, unique and different.

Of nurses’ freedom to speak, Johns (1999:241-242) highlighted that, ‘reflection is espoused as empowering’. However, he identified that nurses have minimal authority or ‘freedom’ to reflect in their day-to-day practice. Further, he claimed that nurses’ voices were ‘silenced by more powerful figures anyway’ (Johns 1999:242).

From a feminist postmodern perspective my additional emancipatory intent was to trouble and destabilise the participants’ taken-for-granted knowledges and to raise issues and awareness of subjugated knowledges (Lather 2001a:207). My intent was to challenge the MLWNs within the safe and trusting context of their telling of their experiences as potentially liberating efforts for both parties. To enhance the telling of their stories the feminist research principle of non-hierarchical relationships was an important feature of the ethnography, as discussed below.

**Non-hierarchical Relationship**

Burgess (1991) explored the role of friendships between the researcher and the participants in terms of engagement and maintaining them in the ethnography. His notions and experiences were similar to that of feminist researchers, in that ‘during the course of any ethnographic project researchers get to know individuals in different degrees of intensity’ and that ‘friendships require mutual sharing and obligation’ (Burgess 1991:51). He also argued strongly in favour of friendship developments as ways to ‘open up’ (Burgess 1991:51) access to social situations for the researcher. Shaffir (1991:73), also not a feminist, found that gaining entry into the field ‘depend[ed] less on the execution of any scientific canons of research than upon the researcher’s ability to engage in sociable behaviour that respects the cultural world of his or her hosts’.

Campbell and Wasco (2000:frame 1) highlighted that a principal feature of feminist research aimed to reduce ‘the hierarchical relationship between researchers and their participants to facilitate trust and disclosure’. Further, Christine Webb (1993) also noted of this egalitarian relationship that the
products of the research must be provided to the women to enhance their insights for personal change. Glass and Davis (1998:46) highlighted that feminist research methods based upon non-hierarchical relationships, fostered sharing and reciprocity which ‘has been clearly perceived as a solution to verbalizing oppressive experiences’. The non-authoritative voice of the researcher, an egalitarian way to reject hierarchical relationships, representation or speaking for the ‘other’ espoused by feminist and postmodernists (Parsons 1995:23) was critical in my approach to the ethnography.

The notion of egalitarianism was also extended to ownership and management of the data, as discussed below.

**Data Ownership and Management**

In relationship to feminist data ownership Lather’s (1991c:58 emphasis in original) assertion highlighted for me that, ‘researchers are not so much owners of data as they are “majority” shareholders’ who must justify decisions and give participants a public forum for critique’. Her stance was significant in the way that I sought three member checks with the MLWNs: to authenticate the transcribed ethnographic data; critique and comment upon my early phase data analysis and emergent insights; and to affirm my selections of their ‘realist’ experiences for inclusion in the thesis as both a check to protect their identity and gain agreement that the selections were their ‘voices’.

In a similar manner to Seibold (2000:150), I fully recognised the ethical implications inherent in how I managed all aspects of the ethnography, especially the MLWNs’ identity. From the first encounters with prospective participants, through to the completion of the thesis I was aware of my ethical obligations. In the field, for example, situational ethics (Fontana & Frey 2000) meant that in all the array of interactions between the MLWNs and other people, staff and patients, was a constant responsibility for me to respect peoples’ rights, avoid any exploitation, prevent ethical dilemmas or problem-solve situational ethical risks to retain the anonymity for all concerned (Hammersley & Atkinson 1996). The pursuit of the research was secondary to being ethical with the MLWNs and those within their cultural context.
There were a number of ways that I actively applied an ethical approach to my research. The nature and purpose for my research was fully discussed with each MLWN prior to their consenting in writing to participate. They were verbally and in writing informed they could withdraw at any time without penalty and that professional counseling would be available if the research process created distress. They were aware that I was not seeking to assess their performance, other staff or the hospital. Further, they were informed that I would not interfere in practice-related activities that put them or other staff or patients at risk of embarrassment or psychological distress. The MLWNs were assured that their identifiable data would be kept anonymous and stored in a secure place and eventually burnt or shredded to eliminate risk of personal identity exposure.

The MLWNs were also aware that as a participant-observer my assumptions and opinions would be included and critiqued within the data. The MLWNs trusted that it would be their voices that were centred in the thesis and that I would analyse data framed within a feminist postmodern perspective and seek, at different levels of analysis, their affirmation of emergent insights. I self-monitored the power relationships with each MLWN and fostered reciprocity and reflexivity in our dialogue. I framed my ethical concerns around Lather’s (1991c:16) challenge of, ‘how do our very efforts to liberate perpetuate the relations of dominance?’

The features of trust and ethics were also integral to the way that I considered structuring the ethnographic thesis, as discussed below.

**Ethnographic Writing**

Of note was Richardson’s (1991:36) comment in that in ‘forging a writing-union between feminism and postmodernism was, thus, a seriously difficult task’. And as a deliberate act it became a ‘site of moral responsibility’. Further, Stacey (1991:113) alerted me to be cognisant of the ethical concern that ‘precisely because ethnographic research depends upon human relationships, engagement, and attachment, it places research subjects at grave risk of manipulation and betrayal by the ethnographer’. Thus, in ethnography framed within the emancipatory feminist postmodern perspectives it was crucial, as the
ethnographer, that I de-centre myself as an authoritative person and to position myself as one who was on an equal stance with the participants. The focus for me, in this role, was strongly directed to make ‘visible’ participants’ respective context of individually unique and different meaning-making of their knowledge from where they were at and not from an assumed ethnographer’s authorial discovery and judgment of them.

Ogle and Glass (2006:frame7) resituated the stance of the feminist postmodern ethnographer to a new and ontologically different level whereby they positioned the ethnographer on the same plane as that of participants, as a ‘nonunitary or mobile subjectivity’ and that ‘rather than presenting the thesis as a text that represented a unitary truth’. Ogle and Glass’ (2006) asserted that critical feminist postmodern ethnography fully embraced a polyvocality and multiple subjectivity methodological approach.

From the commencement of the ethnography I acknowledged to each participant that from the research my academic aim was to achieve a doctoral qualification. As such, the participants were aware that although my effort was toward a non-hierarchical relationship with them during the ethnographic process it would be my authorial privilege, and accountability, to construct the thesis using their data. One principal discrepancy in our relationship was the power I exercised over the participants in what theoretical perspectives I chose, the method for the investigation, the literature I drew upon to support my intentions, what data I selected and rejected to collect and analyse, and the construction of the final thesis. These kinds of ethical considerations reflected some of the risks associated with researcher bias bound by rules inherent in the undertaking of a university qualification.

Of researcher bias, more than thirty years ago, Spradley and McCurdy (1972) detailed risks confronting the investigator. These authors claimed that the researcher ‘wants his account to be free from distortion and bias, to accurately represent what people know and believe’ (Spradley & McCurdy 1972:18). However, no researcher’s observation could be identical to what was actually said, experienced or felt by those under investigation - there was implicit subjectivity inherent in the interpretations made by the investigator at the point

Within the postmodernist frame the practices of reflexivity and intersubjectivity sought to resolve the positivist’s problem of the privileged researcher’s authorial position of representation or appropriation of the other (Lather 2001a). These practices further permitted the researcher ‘reading herself or himself into researcher narratives, or reports, about their own research findings’ (Parsons 1995:24).

It was my explicit intent to avoid the authorial privilege to objectively explain the MLWNs’ narratives, that was, to ‘speak for them’ as this would have demonstrated that my ‘knowledge’ was more correct than theirs (Wiltshire 1995:77). My implicit and explicit intent was to analyse their data applying particular theoretical perspectives in order to reveal new and different meanings to the MLWNs’ realist experiences. The revealed insights may also be valuable insights for the MLWNs and to other nurses and women in similar bureaucratic positions. However, I was also cognisant that ‘meanings and discursive practices are constant sites of struggle’ (Townley 1993:frame 13). There were multiple possible interpretations to the data and analyses. I understood that I could not re-present the MLWNs’ reality as a full account of their experience because my inscription of their experiences was partial, historical, fragmented, relativistic and contextually constructed.

Of feminist critique in which ‘the spirit of reflexivity’ aimed to uncover bias DeMarco, Campbell and Wuest’s (1993:30) point held significance for me. They highlighted that ‘knowing that both self-critique, critique of other’s prior work, and critique of one’s own work by others is as necessary a part of scholarship as is creating new investigations and ideas’ (DeMarco, Campbell & Wuest 1993:30).
I was familiar with the cultural context for the ethnography. However, I was not experienced in the actual functions and life-world of nurses whose primary function concerned day-to-day middle-level responsibilities of the hospital’s core business. The MLWNs core responsibilities were the provision of patient care through the practice of clinician nurses or by their direct patient care practices. However, in the context of the ethnography as participant-observer I was clearly both an insider and an outsider (Bonner & Tolhurst 2002:7). I shifted constantly in and between these spaces, not in a binary fashion but in an unconsciously fragmented manner. It was a process of shifting internal reflexivity and multiple subjectivities to try to make sense of what I experienced in a multiplicity of ways. I recognised that my multiple subjectivities would ‘offer new angles of vision and depths of understanding’ (Sherif 2001:437) which had the possibility to contribute to the depth and breadth of revealed meanings of the MLWNs’ experiences.

The ethnography aimed specifically to centre each MLWN as one form of validating each as legitimate knowledge producers based upon their lived experiences. Thus, inherent in my aim was the notions asserted by Spradley (1980:14) in that, ‘before you impose your theories on the people you study, find out how those people define the world’.

Taking the matter of my ethical responsibilities further in relation to the MLWNs’ storytelling the next sub-section discusses the legitimacy of storytelling as a feminist methodology.

**Narratives and Stories**

In respect to nurses and their stories of their experiences Tina Koch articulated:

> Often core activities of nursing are taken for granted by nurses themselves and sometimes these activities are undervalued by its practitioners … People live stories, and in their telling of them, reaffirm them, modify them, and create new ones. Constructions of experience are always on the move. (1998:1183)
The telling of stories facilitated understanding of those stories. Koch (1998) framed her challenge of storytelling as a legitimate research product within the context of Gadamer's philosophical hermeneutics. This context meant asking 'what is “going on” while researching', rather than as a procedure for analysis (Koch 1998:1182 emphasis in original). Koch (1998:1182) viewed the story 'as interpreted work communicated through writing as the research product'. Koch’s (1998:1183) claim that 'stories can make nursing practice visible' affirmed for me that it would be in the stories of their everyday experience told by the participants that a wealth of unique knowledge existed. Walker (1994) used ethnography with nurses especially because nursing had a long history of being an oral culture. Chiarella (2002) and Street (1992) also affirmed nursing’s long oral history. Walker (1994:165 emphasis in original) further noted that nurses’ communication was 'one mediated through embodied language in which the nurse’s identity and practice are discursively constructed through metaphor such as the “hands on” and the “handover”.

Credibility of stories, as suggested by Koch, (1998:1188) was enhanced 'when it presents faithful descriptions’ and when ‘readers confronted with the experience can recognise it’. The use of stories as feminist research requires the researcher to address issues of reflexivity, subjectivity, voice, politics and empowerment. These research features were integral to my ethnography which was discussed in earlier parts of this section. Feminist notions for ‘finding voice and being heard’ (Glass 2007:119) was an implicit metaphor for narrative and storytelling linked with consciousness-raising by women. Of critical feminist research methodology, Walter, Glass and Davis (2001:270) noted that storytelling ‘affords the participants the forum to define their own reality and represent themselves, and therefore, is an effective technique for discovering the social experiences of silenced women’. Quoting from Cotterill and Letherby (1992) Walter, Glass and Davis added weight to the feminist’s benefit of using storytelling as method in that:

The narrative technique allows respondents to ‘tell the story’ in whichever way they choose and, importantly, validates individual experience and provides a vehicle through which this experience can be expressed to a wider audience. (2001:270 emphasis in original)
In preparing to present the women’s stories, as a feminist’s situatedness of acknowledging women’s knowledge, within the context of my data analysis I took particular note of Lather’s (2001a) considerations. Lather (2001a:209) claimed that it was not an easy decision in ‘trying to find a form that enacts that there is never a single story and that no story stands still’ and as a multilayered approach ‘it risks a choppiness designed to enact the complicated’ lived experiences’. This was not dissimilar to what Manias and Street (2001a) experienced in their critical ethnography informed by poststructuralism with critical care nurses. They noted that both the researcher and the nurses moved between different discourses in the telling of their stories based upon their context, experiences and what value they placed upon the particular discourse (Manias & Street 2001a). Further Manias and Street (2001a) struggled to find a non-linear, flexible way of presenting their participants’ multiple voices as well as managing those parts of their data that were left out. I was also mindful that I could not create a text that incorporated all of the data nor that it would have a storyline or plot, unlike that of an autobiographical ethnography (Ellis 2004:337).

In addition to the ethical issues discussed throughout this section so far, and that had been included and approved in my SCU research proposal, there were further ethical research considerations implicit in the methods I used. Other ethical considerations included my methods to collect and analyse the data to add rigour, an audit trail, and credibility. The following discussion relates to the multiple methods used to collect and analyse the data.

**Triangulated Data Collection and Insights**

I agreed with Parson’s (1995:23) description of data when she claimed that the ‘idea that a researcher can somehow elicit and/or observe experience directly, then analyse that and reformulate it into a sophisticated analysis that presents an authentic, clear statement of the everyday world of research participants finds its epitaph in postmodernism’. However, by applying a triangulation of techniques in qualitative research (Ballinger 2006; Denzin & Lincoln 2000, 1994) I aimed to strengthen the rigour, breadth, richness, confidence, validity and credibility of my ethnographic data collection and analysis. It was also an alternative to quantitative validity. Multiple methods supported an audit trail and built empowering links throughout the research process and supported research
credibility (Taylor 2002d) and was particularly suitable for nursing related research because it also reflected ‘the non-linear, messy but purposeful and coherent reality of nursing’ (Ramprogus 2005:4).

The triangulated data collection methods I chose included:

- Participant Observation inclusive of recording of extensive Field Notes
- Critical Conversations with each participant
- Reflective Journalling by the researcher
- Multiple member-checks

The use of multiple methods provided depth of information gathering which aimed to ensure the MLWNs’ stories, experiences and cultural context were not viewed or analysed superficially or erroneously. Rather, the multiple data collection methods provided me several opportunities. Firstly, to seek further clarification and meaning of what each MLWN did and said. Secondly, to seek clarification and/or checked my biases and assumptions against each MLWN’s feedback. Thirdly, to reflect upon aspects of their experience that I assumed were taken-for-granted.

Muecke (1994:190) supported the use of multiple data collection methods in the field whereby the ethnographer was ‘the equivalent of a multivariate analyst, sorting and exploring on the basis of implications of comparative and contrastive information’. Aligning with the concept of being a feminist postmodern multivariate analyst Anderson and Jackson (1991:11) highlighted that in order to ‘hear women’s perspectives accurately, we have to listen in stereo, receiving both dominant and muted channels clearly and tuning into them carefully to understand the relationship between them’. Further, Boyle (1994:63 emphasis in original) supported the view that even the traditional ethnographer had to be responsive to multiple responsibilities in his claim that ‘two views, emic and etic, side by side, produce a “third dimension” that rounds out the ethnographic picture’. My own perspectives, experiences, assumptions and construction of the analysis would be additional forms of insights that would fit with the principles of contemporary feminist postmodern approaches to qualitative studies (Glass 2000).
Although Spradley and McCurdy (1972) came from an objectivist empirical perspective, they noted that the researcher needed to be systematic. This systematic process included the observation and recording process, description of participant's own words and classifications, being aware of one’s own ethnocentricities and framing the focus of the observations within a specific theoretical perspective. The following four sub-sections details the multiple data collection methods I used and that supported Spradley and McCurdy’s (1972) recommendations.

**Participant Observation**

Participant observation related to the ethnographer establishing a place in the natural setting for a period of time in order to ‘investigate, experience and represent the social life and social processes that occur in that setting’ (Emerson, Fretz, & Shaw 2001:352). According to Denzin and Lincoln (2000:5a), ‘objective reality can never be captured. We can know a thing only through its representation.’ Code’s (1991:224) feminist perspective, as noted earlier in this section, was somewhat different in that her intersubjectivity approach to knowledge construction related to ‘communal practices of acknowledgement, correction, and critique.’ This concept also aligned effectively with philosophical hermeneutics’ meaning-making through dialogue (Schwandt 2000).

Code’s analysis of feminist epistemology provided a relevant approach for me in respect to subjectivity versus objectivity in the field in that:

Claims to know a person are open to negotiation between knower and ‘known’, where the ‘subject’ and ‘object’ positions are always, in principle, exchangeable. In the process, it is vital to watch for discrepancies between a person’s sense of her own subjectivity and a would-be knower’s conception of what it is like to be her. (1991:38 emphasis in original)

Johnson (1992) identified that, ethically, the participant observer needs to identify themselves as a researcher, fully inform participants of the purpose and use of information gained, and inform participants that any potentially
embarrassing behaviours or other negatively revealing behaviours will not be reported. The risk for MLWNs to feel betrayed required my disclosure and establishment of a very high level of trust. Lipson (1994:353) also fully endorsed the ethnographer’s ethical responsibility of ‘regarding people primarily as ends rather than means’. Hammersley’s (1992) comment was also relevant in that because the ethnographer selected what will be in the final analysis they should also make known the values and relevances that underpin the ethnography.

Johnson (1992:217) alluded to the risk of the Hawthorne Effect when in the field when she claimed that participants ‘take special care when someone is watching them’. Using the results of the Mayo 1933 experiment at the Hawthorne works of the Western Electric Company into the effects of workers’ production levels using lighting changes, Lee (2000:5) drew attention to the risk that ‘simply by their presence researchers could unwittingly but systematically distort their own findings’. In his studies, Shaffir (1991), and that of Gerrish (1997), also identified these kinds of risks. These concerns were potential effects for me to keep in mind.

As Kellehear (1993) noted, familiarity of the cultural ethnographic context by the observer could facilitate the investigator’s attention to participant’s experiences that were both familiar and taken-for-granted. It was within this perspective that I aimed to gain understanding of Walcott’s (1994) suggestion, in that the researcher partially needs to ‘stand back’ while in the mode of data collection and refrain from making my own interpretations in order to more fully focus on the participant’s meanings and interpretations of their experience. However, I believed I would most likely be in the same frame as Rudge (1996:146 emphasis in original) when she acknowledged that ‘as a nurse, researching nursing, it became only too apparent that “the nurse” within me, a nursing subjectivity, was a crucial aspect of my participation in the “field”’.

I was fully aware and sensitive of the risk that in the role of participant-observer and interviewer that I may have imposed my bias onto participants. This potential situation was clarified by feminist perspectives in which the role of researcher was to centre woman participant’s voices and not that of the author (Glass 2000; Harding 1997; Lather 1991b; Lugones & Spelman 1999). Martin-
McDonald (1999:224) claimed that ‘a postmodern approach will view the participant as the meaning-maker, accepts that a story may speak in different voices to different listeners, where the researcher is one of them’. Muecke (1994) provided further support to the relevance of intersubjectivity and reflexivity within the ethnography, in respect to meaning making possibilities.

In addition to participant observation, field note-taking and critical reflective journalling were integral data collection methods, as discussed in the next subsection.

**Field Notes and Critical Reflective Journalling**

Field notes comprised researcher’s observations and reflections about the ethnographic field. They were ‘writings produced in or in close proximity to the field’; they were a form of ‘representation’ (Emerson, Fretz, & Shaw 2001:353 emphasis in original). Drawing from Geertz’ (1973) work Emerson, Fretz, and Shaw (2001:353 emphasis in original) noted that ‘in writing down social discourse, the ethnographer “turns it from a passing event”, which exists only in its own moment of occurrence, into an account, which exists in its inscription and can be reconsulted’. Further, field notes were ‘inevitably selective’, ‘descriptive’, and a ‘corpus’ of illogical bits of information that may or may not end up in the final text (Emerson Fretz, & Shaw 2001:353 emphasis in original).

These authors recognised that the recording of field notes as a form of representation was antithetical to postmodernists. However, I took the view that I would need some account of events in order to assist in jogging my memory of the cultural context with each participant rather than as a means to represent an objectivist perspective. Such note taking would support a focus on the uniqueness and difference experienced by each participant rather than as a collation of notions aiming for a generalisable objectified account of the ethnographic sites. Further, as Van Loon (2001:280) affirmed for me of ethnography that ‘the unfolding event is never the same as its written inscription’. However, my field notes aimed to form points of reference of my critical reflections and observations pertinent to each MLWN.

Unobtrusive observation methods, such as field notes and reflective journalling in the ethnographic site were examples of multiple data collection methods.
Kellehear (1993:5-6 emphasis in original) stated of these methods that, such ‘measures tend to assess actual behaviour as opposed to self-reported behaviour’. It also meant that insights from one method could be explored further in another method. Glass (2000) highlighted the benefit for the feminist researcher to use reflective journalling, as a form of both personal and interpersonal reflexivity. Street (1995:145) asserted that journalling enabled the writer to ‘identify and clarify the taken for granted assumptions’. Glass (2001c:4) viewed field notes as critical data collection processes which facilitated recordings of ‘observations of overt and less overt emotions, and, in particular, comments which affected a change in interpersonal interactions’. My intent was that from my field notes and reflective journal notes issues of concern and interest that emerged would also help frame the focus for the critical conversations with each participant as well as being data integral to the whole ethnography.

Critical conversation, as discussed below, with each MLWN also formed an integral part of the triangulated data collection methods.

**Critical Conversation**

Sorrell and Redmond (1995:1118) differentiated the interview structure between phenomenology and ethnography in that,

> Ethnographic interviewing is aimed at describing the cultural knowledge of the informant. In contrast, phenomenological interviewing is concerned with uncovering knowledge related to specific phenomena.

Semi-structured critical conversations were integral opportunities for the MLWNs to explore, reveal and reflect about experiences. The purpose was not only aimed to raise their consciousness but also opened opportunities for them to listen to their own ‘words’ (Reinharz 1992:19) or voices. Within a research context, the opportunity to speak may, for some women participants, be perhaps their first time (Glass 2003b). In the telling of their story was their subjective voice expressing ‘spontaneous ideas, feelings, opinions and insights uncluttered by cognitive concern’ (Johns 1999:244). From a Foucaudian perspective Townley (1993:frame 11) noted that this kind of self-reflection and
disclosure was like a confessional in that part of its value was that it ‘produces information that becomes part of the individual’s self-understanding’. Although nurses readily talk about their experiences with other nurses it was not often that a nurse had the opportunity to feel really heard or safe to speak and be de-silenced (Glass 1998) as could occur within a research context like feminist-reflexive ethnographic conversations. These notions to foster a de-silencing opportunity for the MLWNs were my intentions.

As a feminist researcher I deliberately chose not to create a researcher-authority tick-box identity of the women participants and, thus, did not ask nor record demographic details about each MLWN. Below, in Table 31. ‘Critical Conversation Guiding Questions’, is listed the set of questions given to each MLWN that focused upon my research interest. However, from the outset of our audio-taped conversations I affirmed with each MLWN that the conversation was informal and that the research questions were simply a guide to frame our conversation. With each MLWN I initiated the conversation using an example from my participant-observation experience as an ‘ice-breaker’ (Reinharz 1992:25). I then fostered an open forum for the MLWN to speak for herself. At times during the conversation, when it seemed appropriate and not interrupting the MLWN’s own direction of conversation, I asked direct questions relating to their empowering or disempowering experiences. Each MLWN conversation was unique with a wide variation in topics and duration of focus upon a topic. At the close of conversation each MLWN and I felt somewhat uncertain whether there was sufficient data. As I would not know if the data was adequate or not until I undertook data analysis, I sought verbal consent from each MLWN to extend our conversation if I felt the need to gather more data. No additional audio-taped conversations were required. However, our email and telephone follow-ups as part of ongoing member-checks also became agreed additional data that was incorporated into my analysis and discussion. There was a high level of mutually respectful and friendly interpersonal connection between each MLWN and me that I believed would exist long after the research was brought to a close. The nature of our open communication indicated that the MLWNs did not consider my approach as exploitative; instead, I believed they trusted my integrity to protect their identity yet reveal their voices about particular personal
and professional experiences that they had not previously disclosed to the wider nursing arena.

Table 31. Critical Conversation Guiding Questions

<table>
<thead>
<tr>
<th>Guiding questions for the critical conversation with each MLWN</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Tell me of experiences in which you felt empowered (and inhibited) to achieve your personal, professional and corporate goals within this position? Why do you think this happened? How did these experiences feel for you? What would you do differently next time?</td>
</tr>
<tr>
<td>- Tell me of experiences in which you influenced the shaping of nursing practice or other health professional’s practice within this hospital?</td>
</tr>
<tr>
<td>- What are some examples of work experiences that you have found exciting, empowering, devaluing, confronting, controlling? Why?</td>
</tr>
<tr>
<td>- What cultural changes do you think are needed to enhance your role as a MLWN in the hospital? Why?</td>
</tr>
</tbody>
</table>

In ensuring my promises were kept to each MLWN about the research I took serious consideration of feminists’ research analytic interest to collaborate with the women participants as an egalitarian practice. The following discussion explains how I endeavoured to meet a collaborative analytic approach but within the constraints of the formal qualification I was undertaking.

**Multiple Member Checks – Partial Collaborative Data Analysis**

I have detailed in a previous section in this chapter that I drew from various key features of critical social science, feminism, postmodernism and ethnography. One of the most important methodological issues related to my ethnographer role in engaging and collaborating with participants in the construction of knowledge and insights. To achieve this intent required the inclusion of multiple opportunities throughout data collection and data analysis for participants to be actively involved and not marginalised in the process. The characteristics of reflexivity, reciprocity and intersubjectivity inherently related to a collaborative approach to negotiate the meaning of participant’s realities of their experiences and, thus, the outcomes of the investigation. There would, inevitably, be limitations on the success of such desires to create research that was fully egalitarian; at best, I could only make explicit particular opportunities to involve the participants in meaning-making.

Manias and Street (2001a) recognised the risk of their researcher efforts to engage their participants collaboratively in the analytical process. Their very
effort to do so was disempowering for some participants (Manias & Street 2001a) and similar to Lather’s (1991b) concern.

Each participant was aware that my focus for the study was an integrated feminist postmodern approach – women’s oppression within a patriarchal culture and that I sought to valorise their individual and unique experiences as legitimate knowledge producing sites.

The techniques I used to avoid the risk of my ‘objectifying’ these women as researched objects and my becoming the authorial expert of their experiences are listed in Table 32. ‘Techniques used to avoid objectifying MLWNs’.

<table>
<thead>
<tr>
<th>Techniques used to avoid objectifying MLWNs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Each participant authenticated their respective original transcriptions of our semi-structured conversation.</td>
</tr>
<tr>
<td>• My contacting personally each participant, as integral to my valuing their integrity and connection with the research process, when I sought their consent to comment upon their respective preliminary data analysis, my selection of their dialogue that I included in the thesis as representative of their ‘voices’, as well as the insights that emerged about their ‘silences’.</td>
</tr>
<tr>
<td>• Acknowledging with each MLWN that our ongoing communication was meaningful to me in that our free-flow open and trusting conversation affirmed these MLWNs were extraordinary nurses deeply committed to nursing and patient advocacy. Further, their willingness to update me of changes in their circumstances was additional ethnographic data that further contributed to the research.</td>
</tr>
<tr>
<td>• My being alert to the ‘evidence of reflexivity, of attending to the assumptions that undergird a particular act of social inquiry’ (Lather 1991b:22).</td>
</tr>
</tbody>
</table>

Having affirmed triangulated data collections methods suited the research question, aim and objectives and once data collection was completed with the eight MLWNs, the most complex research process became apparent – ethnographic data analysis. The philosophical perspectives that I drew upon to support my development of the innovative trifocal multi-phased analytic process is discussed below and detailed in chapter five.

**Trifocal Data Analysis Methods and Emergent Insights**

Coffey and Atkinson (1996), Glass and Davis (2004), and Savage (2000b) argued that data could be analysed more than once and using different
approaches but not for the purpose of collapsing the interpretations into a unified conclusion. The aim of viewing data in multiple ways opened a space for me within which different layers of meaning could be revealed.

As indicated earlier in this chapter no prescriptive method was cited in the literature to analyse ethnographic data informed by feminist postmodernism. As I have contended throughout the thesis my research question, aim and research objectives suited my chosen methodology and methods. Thus, I was confident to assert the suitability to apply multiple and different analytic lenses to the MLWNs’ data. Having previously discussed the need for a structured analytic approach within which my assumptions and processes were transparently evident, I found it necessary to develop a unique analytic process, as an evolved process. This process markedly differed from that proposed in my research applications to the hospitals’ NREC. The multiple lenses through which I viewed the data included: realist, critical feminist (Lather 1991b), Foucauldian postmodern (1980), and feminist postmodern (Lather 1991b).

The analytic model that I developed revealed six frames of emergent insights, each with a different but interrelated perspective to each other. These insights are discussed and critiqued in detail in chapter six and were introduced in chapter one.

**Summary of Section 5. Principles Inherent in the Ethnography**

Taking into account the multi-focused feminist postmodern philosophical perspectives it was obvious to me that ethnography, as both methodology and method, especially complimented my research question, aim and objectives. I believed reality and knowledge were socially constructed and, thus, the cultural context of ethnography was the site in which local, contextualised, historical and partial knowledge could be understood, heard, celebrated and legitimated. Concurring with Heckman (1999), I believed the cultural context was not a site of trivial knowledge production. Other qualitative research methods, such as phenomenology or grounded theory, would not have effectively supported the depth, breadth, and scope of opportunity to understand the feminist oppression narrative of individual MLWN’s experience within their multiple and dynamic cultural contexts of WA public hospitals.
Philosophically, ethnography afforded a space in which the etic and emic perspectives of the researcher and research participants could be intertwined intersubjectively, reflexively, and reciprocally in a mutually equitable dialogic meaning-making process. Embedded within my feminist emancipatory interest it was to ethnography that I believed I could best be with the MLWNs in their working world, in which their day-to-day practices and interpersonal relationships could be unscripted or unconstrained. The multiple methods for data collection suitable to ethnography meant that, as researcher, I could be a participant observer, integrally embedded in the research process. Such a local and contextualised situating meant that I could also openly observe and dialogically discuss with each MLWN their lived experiences. These were ways to understand and reflexively critique their multiple realities, their tacit and implicit knowledge of how they self-managed the tensions between their corporate and professional nursing roles. Being in their world would provide the space wherein I could foster an empowering, non-hierarchical and trusting safe space within which they could speak. Ethnography would provide the context within which the voices of MLWNs could be locally heard and valorised. This method supported the sharing of stories, fostering opportunities for consciousness-raising of the cultural context of competing dominant and subjugated discourses that impacted upon their day-to-day professional relationships, and explore their taken-for-granted practices.

Ethnography as methodology and method would afford me the freedom to embed my philosophical premises and, thus, to deeply address my research question, aim and objectives in contrast to alternative qualitative research techniques that were restrained by positivist frameworks or expectations of the creation of a universalized theory.

**Summary Comments on the Chapter**

This chapter sought to affirm the suitability and interconnectedness of the philosophical and practical perspectives that framed my research question, aim and objectives. My research interest specifically sought to foreground the implicit taken-for-granted knowledge of eight experienced senior middle level women nurses who practised within the cultural context of WA public hospitals during the period of 2003 to 2006. My research intent was not to propose a
generalisable theory or insights that could be attributed to other nurses in similar working positions or other health care settings. My specific interest was to create space within which the voices of the research participants and the insights derived from a multi-lensed interconnected analytic approach to their narratives of their experiences could be valorised as important contributions to their self-understandings as well as to the body of nursing and social science knowledge.

Teasing out the various philosophical principles, insights and concepts from critical social science, feminism, postmodernism, feminist postmodernism and ethnography that influenced every aspect of this research required substantial clarification. Each theoretical paradigm as a methodology consisted of complex, some complimentary and competing, epistemological viewpoints, and when integrated were unfamiliar within the nursing research arena. I believed it was important that my justification for the suitability of this research methodological frame be detailed in order to confidently lay a modernist feminist and postmodern claim that the women in this research were valid knowledge producers.

The endeavour of an ethnography informed by feminist perspectives of women’s oppression narrative with political emancipatory intentions integrated with postmodernism features sought to support the legitimacy of women’s knowledge, at the individual, localised and particular level and that was inherently personally political. The principles that I drew upon and ethnography as the method aimed to disrupt and interrogate traditionally held views of the culture within which MLWNs existed. My aim was to expose the patriarchal dominated construction of that culture and to facilitate efforts to foreground the validity of women nurses’ experiences and reveal their personal skills that were empowering and/or transformative. The MLWNs’ self-managing strategies used to meet their corporate and nursing professional work responsibilities, a site of potentially competing tensions, was assumed to be poorly valued and even less understood. The taken-for-granted personal skills and knowledge of MLWNs, as one of my assumptions, was inadequately acknowledged as the critical hinge in a public hospital system that made good patient care possible and fostered retention of nurses in the workforce. My assumptions were based upon my
experience that too often others took the credit for this outcome with rare recognition of this group of nurses, most of whom were women. Thus, it was to have these MLWNs’ individual and different voices heard that I focused this project.

Chapter five details the processes I used to collect and analyse the data. These processes specifically aligned with the philosophical premises as discussed in this chapter and which addressed the research question, aim and objectives.
Chapter 5.
Revealing MLWNs’ Voices - Trifocal Methods
**Introduction**

In preparing to analyse each MLWN’s data I frequently reviewed the methodological principles that informed the research. My purpose was to ensure my analytic focus aligned with feminist postmodern methodology.

This chapter comprises two sections. In the first section I expand upon my methods used to engage the participants. I also explain my methods for subsequent participant observation and critical conversations with each MLWN.

In section two I detail, in a structured manner, the analytic processes I developed to analyse the transcribed realist data: audio-taped critical conversations, my field notes and critical reflective journal. This structure aims to demonstrate the analytic process that revealed meaningful insights of interest, relevance, credibility and new value to the body of nursing knowledge.

In the previous chapter I detailed the philosophical and methodological principles that informed the ethnography. This detail included the various methodic considerations integral to undertaking the ethnography, such as multiple data collection techniques, validity and ethical issues, multiple member checks and other interconnected aspects of feminist postmodern research technique. I was mindful that the integration of methodology with method was a critical component of the thesis (Glass 1998). The details of the ways I endeavoured to retain the integrity of the research question, aim and objectives are presented in this chapter. Taylor (2002a:451) indicated that there is ‘very little direction in the nursing literature as to how to go about qualitative research interpretations’. I was also acutely aware that the analytic methods that I eventually created, that served my purpose, would require ‘long dedicated testing to determine [its] worth in terms of scientific merit’ (Chinn 2004:frame 1). Thus, this chapter aims to explicitly detail the structured approach to analysis and meaning-making of the ethnographic data in full recognition of its innovativeness.

The analytic process is presented, below, in Table 33. ‘Ethnographic Multi-Phased Analytic Process Applied to the Data’. The title for each phase of the data analysis process is also included at the commencement of detailing the
process applied to each phase of analysis. The aim is to highlight where each phase fits within the total analytic process.

Table 33. Ethnographic Multi-Phased Analytic Process Applied to the Data

<table>
<thead>
<tr>
<th>Phases of Data Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1. Authentication of Transcribed Realist Data &amp; 1st Member Check</td>
</tr>
<tr>
<td>Phase 2. Realist Analysis of Realist Data (objectives 1-3)</td>
</tr>
<tr>
<td>Phase 3. Critical Feminist Analysis of Realist Concepts (objectives 1-3)</td>
</tr>
<tr>
<td>Phase 4. Postmodern Foucauldian Analysis - Emergence of Discourses in the MLWN’s Cultural Context (objective 4)</td>
</tr>
<tr>
<td>Phase 5. Alignment of Realist Exemplars against Emergent Postmodern Discourses (objectives 1-4)</td>
</tr>
<tr>
<td>Phase 6. Integrated Feminist Postmodern Analysis of Realist Experiences</td>
</tr>
<tr>
<td>Phase 7. Emergent Feminist Postmodern Insights of MLWN’s Self-Managing Strategies &amp; Implicit Knowledges (objectives 1-4)</td>
</tr>
<tr>
<td>Phase 8. Draft Data Analysis - 2nd Member Check</td>
</tr>
<tr>
<td>Phase 9. Preparation for Discussion – Chapter 6 The Voices of MLWN’s Experience &amp; 3rd Member Check</td>
</tr>
</tbody>
</table>

Summary of Trifocal Methods & Researcher Assumptions

In order to support the link between the analytic processes as detailed below I refer again to the research question and the four interconnected objectives that framed the integrated feminist postmodern ethnography.

**Research Question**

What meanings do middle-level women nurses attribute to their experience of practicing in Western Australian public hospitals?
### Research Objectives

<table>
<thead>
<tr>
<th>Research Focus</th>
<th>Research Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Experiences</td>
<td>➢ To explore and reveal issues (experiences) that are common, different, unique and exceptional that foster (empower) and constrain (disempower/oppress) the participants’ personal, professional and corporate efforts toward their own empowerment, emancipation and transformation.</td>
</tr>
<tr>
<td>2. Self-Managing Strategies</td>
<td>➢ To explore and reveal ways that the participants create opportunities within their work setting for enhanced self-management.</td>
</tr>
<tr>
<td>3. Power Relations</td>
<td>➢ To describe and critique the participants’ perceptions of the impact (power relations) on them of the hospital’s organisational culture in regards to their personal, professional and corporate responsibilities.</td>
</tr>
<tr>
<td>4. Discourses</td>
<td>➢ To review and critique the discourses (common assumptions) that frame the practice of Middle Level Women Nurses</td>
</tr>
</tbody>
</table>

The following discussion, section one, focuses upon the methods I applied to engage the participants into the research project.

### Section 1. Accessing the Ethnographic Field

**Introduction to this section**

In this section several aspects are discussed that related to my journey of traversing the nursing research pathway to gain approval to invite prospective participants into the research. At times, my experience was personally oppressive and disempowering. At other times I was deeply grateful for the support provided by colleagues. My experience was similar to Hodgson’s (2001) difficulties in accessing hospitals as research sites. I was also grounded by Burgess’ (1991:43) claim that ‘access is negotiated and renegotiated throughout the research process’ and that it is also ‘linked to the politics of social research’.

In the next part of section one I explain the process I used to gain research proposal approval.
Gaining Research Proposal Approval
My initial application to Southern Cross University Human Research Ethics Committee (SCUHREC) was accepted in early 2001. Once university approval had been granted I pursued gaining approval from three public tertiary hospitals in Perth, WA. The first hospital’s Nursing Research Ethics Committee (NREC) to approve my proposal was finalised in July, 2002, the second hospital’s NREC proposal was accepted in February, 2003, and the third hospital’s NREC approved the proposal in March, 2003.

At the time I was preparing to gain approval to access potential participants there were thirteen public hospitals in the Perth metropolitan area of which five were tertiary hospitals. Each of the tertiary hospital’s executive management was responsible for more than one public hospital within a designated geographical area as established by DoHWA. Each tertiary hospital also convened its own NREC with representatives drawn from its own nursing staff and experienced nurse researchers from different universities in Perth.

My interest was to engage participants from more than one hospital site because I sought to understand the broader socio-political cultural context of WA public hospitals from the perspective of the participants. In particular my interest was in how the public hospital culture influenced them in their day-to-day practice. It was not my interest to compare and contrast hospital cultural contexts. Nor did I wish to single-out one hospital. Consequently, throughout the thesis I chose to relate any discussion about the hospitals without indicating in which hospital the participants’ were located and, thus, to ensure the hospital’s anonymity.

The option to undertake the study in hospitals or health care settings other than public hospitals in WA was not appropriate. The health care system and the nursing structure in WA were different to that of other Australian States and in private WA public hospitals. The roles and responsibilities for MLWNs varied across States. My aim was not to generate a generalisable theory.

I was unsure how many sites I may have needed to access in order to engage the nurse participants. I, therefore, chose to seek approval from three of Perth’s
public tertiary hospitals’ NREC. I chose to gain research ethics approval from one NREC at a time. My assumption was that if my proposal could be accepted by one NREC then I may also be better positioned to gain approval from two other hospitals’ NREC. Each of my three NREC research proposals was similar but adjusted to meet each hospital’s respective NREC criteria. Each proposal was required to meet the National Health and Medical Research Criteria (NH&MRC) (1992) and specific criteria related to the hospital. I also preferred to respond to one NREC at a time in the event that I was requested to make changes or additions to my proposal.

One of the main reasons why I applied to one NREC at a time was because I was uncertain whether my methodology and research sites would be approved. As identified from the literature review, feminist postmodern ethnography was not a familiar nursing research design at the time I submitted my proposals. Further, my dilemma was that feminist postmodern ethnography did not easily fit within the NH&MRC criteria and which featured in the NREC criteria. NH&MRC guidelines were heavily weighted toward the positivist quantitative scientific method. My dilemma was ethical in nature and primarily related to having to modify my research proposal to NREC from that which had been approved by SCUHREC. The modifications also related to minimising discussion of feminism. I was concerned about the negative connotations attributed to feminist research because of the historical resistance by many nurses to align with feminist perspectives of patriarchal oppression. I had been a resistor of feminism until I began to explore the possibilities for this ethnography. The modifications to my proposals also included extensive details about a data analysis method. The analytic method I presented was drawn from a generic qualitative research text (Maykut & Morehouse 1994) and which from the outset I knew to be unsuitable for my research aim and objectives. I was mindful of Seibold’s (2000:abstract) feminist postmodern research experience in which she asserted that ‘the design cannot be fully specified in advance, but rather emerges over time’.

However, the proposals met with NREC member’s approval. I also recognised an opportunity within this research to create a structured method as an innovative contribution to the body of nursing and social science knowledge.
The need to be peer reviewed for my research proposals demonstrated to me the continuing tensions between the dominant positivist ‘hard’ research methods and the ‘softer’ qualitative research processes (Roberts & Taylor 2002c:7). The level of adherence to research proposal rules for each organisation also meant that I was either ‘in’ or ‘out’ of that specific community. This was a one-way challenge and being on the ‘out’ trying to get ‘in’ meant that I had to be flexible and include certain information to satisfy ‘the’ NREC rules.

One NREC raised concern that I was a ‘well known’ educator in the WA nursing community and, as such, participants may only tell me what they thought I wanted to hear. This comment heightened my awareness to assure confidentiality for the participants and their respective employing hospital. The comment also sparked my curiosity as to what the participants, senior experienced women nurses, might make about such a disparaging reference of their untrustworthiness to speak their truths with a researcher whom they may know. One MLWN, to whom I disclosed this NREC concern, was appalled but not surprised!

Related to the NREC concern that I was well known was the risk of investigator bias. I was curious to address this in light of criticism posed by various contemporary scholars (Code 1991; Denzin & Lincoln 2000a, b; Hodgson 2001; Lather 1991b; Spradley 1980) who contended that no research was free of researcher bias. Feminist principles affirmed for me that transparency of my bias (assumptions) was integral to the research process. Kleinman’s (1991:184) comment also provided further assurance to me that in the field the researcher needed to examine their emotional reactions because ‘if you do not, your feelings will still shape the research process, but you will not know how’.

The changes I was requested to make for the NREC did not depart inappropriately from my accepted SCUHREC proposal and I was not required to re-submit my proposal to the university.

The process to gain acceptance to undertake a multi-sited ethnography in public hospitals was initially challenging because all were governed by the Department of Health WA (DoHWA). This meant that a proposal was needed to
be developed and submitted for approval three times. I concurred with Byrne, Morgan, Kendall and Offredy (2005) that it was complex and time consuming to have had to submit three different ethics proposals to three hospital’s NREC.

The next part of section one explains the methods I used to access and engage the eight middle-level women nurses into the ethnography.

**Accessing the Participants**

Unlike quantitative and some qualitative methodologies (such as with phenomenology and grounded theory) my ethnography was not intended to be representative of any ‘population’. I did not seek to attain a ‘sample population’ in order to generate a universal or generalisable theory (Hammersley & Mairs 2004:frame 1).

My first plan to access participants was to initially meet with hospital Nurse Executives. Following their approval I would then be able to meet with nurses at a senior nurses’ meeting, explain the research, distribute Information Sheets, and invite interested nurses to contact me by telephone after the meeting. I chose to role-play this plan with higher degree colleagues and experienced higher degree research supervisors. This occurred while participating in one of the School of Nursing and Health Care Practices, Southern Cross University, bi-annual research seminars. I asked this group of colleagues, many of whom were nurses, to role-play being novice nurse researchers. The negative and highly resistive feedback from this exercise identified that my planned presentation and invitation was too complicated. ‘Proposed participants’ were unfamiliar and resistant to feminist research methodology and had no idea what postmodernism and ethnography meant.

This role-play group suggested I apply the technique of ‘snowballing’. ‘Snowballing’ referred to a method whereby an informant from the research field sponsored or referred the researcher onto potential participants (Streeton, Cooke, & Campbell 2004:frame 2). The risk with this method was that participants may have come from ‘members of a specific network’ (Streeton, Cooke, & Campbell 2004:frame 5). However, my intent was not to generalise
outcomes nor create a theory. I was, therefore, comfortable that it would be nurses interested in the research focus who would consent to participate.

Overall, my method of data collection was the same with each participant. In one hospital site I initially liaised with a nursing colleague who held a middle-level position. She was known to me from an earlier time in my career. This nurse acted as my ‘snowball’ sponsor and organised an informal meeting with about nine other women nurses who listened to my explanation of the investigation. From this group four nurses were interested to participate and contacted me after the meeting.

I organised to contact each of these nurses by telephone to set up convenient times for me to spend three shifts, or longer if needed, with them as a participant observer. Data collection with these four participants was completed within approximately four months. While openly shadowing the participants during their work we talked informally and freely about their experiences of the position they held. I wrote field notes and reflective comments immediately after being at the site. My interest was to capture my thoughts and feelings as close in time to my site observations and informal conversations. There were only a couple of occasions during participant observation where I chose not to accompany the participant, such as when I felt it could have been intrusive to other staff and patients. My audio-taped critical conversations with these participants occurred within two to three weeks of participant observation.

In another hospital I contacted a nursing colleague who also knew me from my work in WA. This nurse also organised an informal meeting with a number of potentially interested nurses. One senior middle-level male nurse contacted me by email raising his criticism that my research was not including males. In response to this nurse’s criticism, I telephoned him and explained that for this research my interest was to include women nurses because of their historical gendered subjugation and that for future research the inclusion of male nurses would form one of my recommendations. Two women nurses contacted me privately by telephone and agreed to participate. Because of our full-time work commitments it took several months before I was able to complete participant observation and critical conversation with one nurse. It took several more
months to be present with the second nurse. One of these nurses also acted as a ‘snowball’ sponsor for an additional nurse who consented to participate. I contacted another nurse, whom I had known for a number of years, and invited her to participate, to which she eagerly agreed. Because of our busy schedules, completion of data collection with the latter participants occurred over a twelve month period.

Snowballing technique opened up the variability of participants into this research. There were senior clinical nurse managers, nurse managers and clinical nurse specialists who consented to participate. I knew six consenting participants from my WA professional nursing activities. Two participants, whom I did not know, knew me from my nursing educational roles in WA. The eight consenting participant nurses had been merit selected into positions located in the hospital’s mid-level nursing hierarchy. They were experienced practitioners directly reporting to a Nurse Executive. All but one consenting participant line managed up to fifty to sixty full-time and part-time clinician nurses. The Nurse Executives held executive corporate positions and were members of their respective hospital’s multidisciplinary corporate team. The level of the participating nurses’ scope of work responsibilities encompassed responding to the multiplicity of traditionally hierarchically structured levels of responsibility. For example, achieving the hospital’s superordinate corporate agenda, principally that of financial containment and accountability, responding to subordinate nurses’ works related needs, and supporting a cultural intent of collaborative multi-disciplinary patient-centred health care. In enacting their roles each MLWN engaged in informal inter-nursing and inter-professional communication and formalised hierarchically constructed relationships with a multiplicity of people.

The collective title I gave to the participants was that of middle-level women nurses (MLWN). The collective title I gave to the corporate level nurse was Nurse Executive.

Relevant ethnographic details pertinent to the consenting participants are presented in Table 34. ‘Ethnographic Details of the MLWNs.’
Table 34. Ethnographic Details of the MLWNs

<table>
<thead>
<tr>
<th>To whom MLWN reported:</th>
<th>Nurse Executive/Director of Nursing (Member of Hospital Executive Corporate Team)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position Title of MLWN:</td>
<td>Nurse Manager</td>
</tr>
<tr>
<td>Line management responsibilities:</td>
<td>40-60 clinician nurses</td>
</tr>
<tr>
<td>No. of consenting research participants:</td>
<td>1</td>
</tr>
</tbody>
</table>

All the nurses who attended the informal meetings organised to explain the research were given an Information Sheet (Appendix 1.), and those who agreed to participate completed a Consent Form (Appendix 1.). All nurses who did not agree to participate were uncomfortable with participant observation. Yet, if the research had been to complete a questionnaire I believed those nurses who came to the informal meetings in both hospitals would have agreed to participate.

The overall investigation was carried out over a seven year period (2000 to 2007) on a part-time basis. Data collection was conducted over three years (2003 to 2006). On completion of the ethnographic data collection with the eight participants I considered I had sufficient depth, breadth and richness of data to effectively address my research question, aim and objectives. Therefore, I did not require access to other public hospitals. During data analysis I sought three forms of member checks with each participant. Their comments and feedback at each member check was incorporated as integral data. Some of their comments have been incorporated into chapter six as their voices.

From the outset of my endeavours to engage the eight participants there was a high level of mutual respect. I believe this fostered freedom for each to speak openly and personally. This openness was also evident in Glass’ (1998) postmodern feminist research with women nurse academics. I was implicitly entrusted with each MLWN’s confidence that I would protect their real identity, sensitively manage their experiences as privately disclosed ‘unsaid’ (Glass
2003b:189), and valorise the emergent knowledges by centring their voices in the thesis.

I was welcomed to be present with each MLWN at all times, including attending middle-level senior nursing meetings chaired by different Nurse Executives, one-on-one meetings between the MLWNs and their Nurse Executive, senior hospital staff meetings, mentoring sessions between MLWNs and other nurses, and lunch get-togethers with colleagues. I was mostly introduced as someone looking into their respective role. At no time did it feel that I was imposing or putting the MLWNs at any risk. Conversations during participant observation were free-flowing and non-stop in which I asked lots of questions and both of us reflexively shared experiences, positive and negative. The level of reciprocity, in my opinion, was exceptionally high and demonstrated that I ‘lived my research beliefs’ (Walter, Glass & Davis 2001:268).

The relaxed reciprocity that I experienced with each participant also continued after data collection. For example, when I contacted them to invite their comments on my first-round data analysis and emergent insights our conversations were friendly and they were eager to receive their ‘next installment’. Having reviewed their respective data analysis the MLWNs responded to me by email or telephone with an update of their experience since last we had met.

I commenced data analysis only after I had completed transcription of all participants’ data. The process I applied for data analysis is presented in the next section.

**Summary of Section 1**

In this section I reiterated an overview of the research focus and restated the research question and objectives. Some of the difficulties and benefits related to my experience in gaining approval to access participants by three WA tertiary public hospitals’ NREC were discussed. I provided detail of my unsuccessful attempt to engage colleagues from a role-play exercise and which formed the basis to alter my process to that of using snowball method to engage participants into the research. In introducing the MLWNs I provided sufficient
description about them for the purpose of the research. The reflexive trusting nature of my relationship with the MLWNs was outlined and clarity of my ethical commitment to these women nurses was described.

In the next section below, I detail the actual processes I applied to analyse the data.

Section 2. Data Analysis

Introduction to this section
In chapter four I argued that there was negligible literature that offered a prescriptive analytic process for ethnographic research informed by feminist postmodernism. Of secondary and multiple layers of qualitative data analysis Woods (2005:frame 2) noted it was ‘still very much in its infancy’. Glass and Davis’ (2004:91) application of their ‘trifocal’ integrated feminist postmodern analytic process provided an impetus and confidence for me to pursue a multi-lensed and integrated analytic approach to the data. On reading further it was found that Glass and Davis’ (2004:91) trifocal model was not directly suitable for my purpose. Hence, as presented in this section, I developed a multi-phased and multi-lensed approach to analyse the data which ensured a focus upon the research question and objectives. My approach focused upon the MLWNs’ realist experiences, self-managing strategies, power relations, and discourses. The multi-lensed analytic approach included: realist, critical feminist, Foucauldian postmodern and feminist postmodern analytical techniques.

The structured analytic approach that is presented below was, however, antithetical to the critically reflexive cognitive and emotional churning of backwards-and-forwards-and-upside-down focus I paid to the data. This multi-reflexive critical thinking aimed to develop a method to gain understanding and make meaning of the data through my multi-focused methodological lenses. In the next sub-section is described the methods I used to prepare the data for analysis.
Preparing for Data Analysis

I considered a variety of data management methods used by colleagues, other higher degree ethnographic students and, in particular other critical feminist researchers and feminist postmodern ethnographers (Cheek 2000; Davis 1998; de Laine 1997; Glass 1994, 2007; Glass & Davis 1998 & 2004; Lather 1991b; Ogle 2004; Ogle & Glass 2006; Street 1992; Walter 2003), postmodern narrative researchers (Boje 2001) and qualitative studies in general (Richards 2005). None of these methods served to adequately help me address the four interrelated research objectives. I needed to create a different and unique way to analyse the data.

What became evident as I embedded myself in the data was the multiplicity of intersecting layers of meanings and insights that could be revealed. I did not view each research objective as stand-alone but as interconnected. Thus, I endeavoured to create a way that would interlink my analytic processes and, whilst avoiding closure of interpretation, keep the options of understanding open, fluid, temporal and locally contextual. My approach integrated continuous self-reflexivity, inclusive of deeply listening with my heart to the MLWNs' narratives. It also included cognitively challenging me to stay close to the raw data. The investigation was conducted as a slice-in-time of each participant’s reality of their work experiences as they understood it at that time. It was, therefore, not representative of any totality but situated within a dynamically shifting and complex political and historical terrain. In my perspective each MLWN’s history was always present, meaning that although their stories may have emerged from different points in time, their disclosed experiences were central to their immediate reality. My participant observations and critical reflective field notes and journal writing reflected the MLWNs’ experiences during the ethnographic data collection period.

What emerged from reading the data, as realist exemplars of their experience, was the dynamic nature of the MLWNs’ experiences where they moved fluidly and unconsciously from one ‘state of being’ to another, and at times simultaneously within more than one state. Methodologically, I recognised that the MLWNs’ changing ‘states of being’, viewed as subjectivity positions, interrupted the possibility for fixed closure of the research. Questions for future
research opportunities arose from data analysis as well as the likelihood for different insights and understandings. Responses from the MLWNs review of their respective draft analysis and emergent insights, for some more than twelve months after their respective ethnographic experience, affirmed the changed and alternative circumstances and cultural contexts for these nurses. However, such changes in their life were to be expected. What emerged from the ethnography continued to have importance for wide dissemination within the nursing profession, locally, nationally and internationally and to others whose roles combined professional and corporate responsibilities.

Introduced in chapter one and detailed in chapter four were the extensive methodological premises that informed the development of a multi-phased and interlinked multi-lensed analytic process. I chose to develop the analytic process with one participant’s data first so that I had a model to apply to the other seven participants’ data, one at a time.

The following sub-sections explain in detail the eight phases of analysis and the phase for preparation for chapter six that evolved. From this process emerged five frames of insights for each MLWN and one collective frame of knowledge insights. Also included throughout this section are various assumptions that I made in order to interconnect the research aim and objectives with my underpinning methodology and methods.

**Phases of Data Analysis**

Below is presented Table 33 ‘Ethnographic Multi-Phased Analytic Process Applied to the Data’ which lists the focus for each of the nine analytic phases undertaken with each MLWN’s ethnographic data.
Table 33. Ethnographic Multi-Phased Analytic Process Applied to the Data

<table>
<thead>
<tr>
<th>Phases of Data Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1. Authentication of Transcribed Realist Data &amp; 1st Member Check</td>
</tr>
<tr>
<td>Phase 2. Realist Analysis of Realist Data (objectives 1-3)</td>
</tr>
<tr>
<td>Phase 3. Critical Feminist Analysis of Realist Concepts (objectives 1-3)</td>
</tr>
<tr>
<td>Phase 4. Postmodern Foucauldian Analysis - Emergence of Discourses in the MLWN’s Cultural Context (objective 4)</td>
</tr>
<tr>
<td>Phase 5. Alignment of Realist Exemplars against Emergent Postmodern Discourses (objectives 1-4)</td>
</tr>
<tr>
<td>Phase 6. Integrated Feminist Postmodern Analysis of Realist Experiences</td>
</tr>
<tr>
<td>Phase 7. Emergent Feminist Postmodern Insights of MLWN’s Self-Managing Strategies &amp; Implicit Knowledges (objectives 1-4)</td>
</tr>
<tr>
<td>Phase 8. Draft Data Analysis - 2nd Member Check</td>
</tr>
<tr>
<td>Phase 9. Preparation for Discussion – Chapter 6 The Voices of MLWN’s Experience &amp; 3rd Member Check</td>
</tr>
</tbody>
</table>

Summary of Trifocal Methods & Researcher Assumptions

Each process within the nine analytic phases is now explained in the following sub-sections.

**Phase 1. Authentication of Transcribed Realist Data and 1st Member Check**

The step-by-step approach I used to authenticate the ethnographic data is presented below.

- Each participant’s audio-taped conversation, my field notes and reflective journal notes were transcribed, on completion of data collection. Transcription was performed by a legal clerical typist who understood the responsibilities associated with the confidential nature of each participant’s realist data.
- Each participant’s transcribed conversation was printed from my home printer and confidentially mailed to them with an accompanying information letter. My letter sought to gain their respective confirmation of the authenticity of their transcriptions. None of the participants made changes to
the transcripts. Those transcriptions remained with each respective participant.

- A Microsoft Word data management computer system was established to ensure security and integrity of data, anonymity of participants and hospitals and as an audit trail for each of the evolved analytic processes. From my home printer one set of original transcriptions were printed and stored in a locked cupboard, were not referred to again, and would be destroyed by burning or shredding five years after completion of the research in accordance with NH&MRC ethics.

**Phase 2. Realist Analysis of Realist Data (objectives 1-3)**

The step-by-step approach I used to conduct a realist analysis of the ethnographic data is presented below.

- I reviewed the research objectives and typed these at the beginning of a Word document for the MLWN.
- Into this Word document I inserted the MLWN’s realist transcribed data: critical conversation, my field notes and critical reflective journal.
- I formatted the transcribed data into a one-column table which split the sentences into rows.
- A second column was created. In this column I created terms to represent abbreviated Realist Data Topics as these aligned with the realist transcribed data. These terms formed the basis of the realist exemplars. These became the ‘reality’ framework of the MLWN’s multiple voices. This reality framework further framed the successive critical analytic phases from which could be revealed unacknowledged and different insights. Further, these realist exemplars provided the frame against which cross-checking could be made to ensure the MLWN’s voices were my centre of focus and not that of my assumptions or personal interpretations.
- I re-read the MLWN’s transcripts several times to ensure I was immersed in her data (the reason I chose one participant to analyse first was because of the profound heartfelt emotion she expressed during our period together - from deep sadness and joy, frustration and her awareness of oppressive and empowering experiences).
**Researcher Assumptions:**
The transcripts were messy, dislocated, unfinished and unclear. This data represented realist exemplars of her lived experiences. Inherent in this data I assumed were the indications of how the MLWN self-managed the nexus of her corporate and nursing professional responsibilities within the cultural power/knowledge constructions of the hospital. Integrrally linked with her self-managing strategies I further assumed may be implicit and unacknowledged knowledge that the MLWN had acquired to guide her self-managing strategies.

My assumptions particularly related to Wittgenstein’s assertion that ‘the ultimate justification for our claims to knowledge is not logic, but simply “what we do. It is what human beings say that is true and false; and they agree in the language they use” (Heckman 1999:128 emphasis in original). My assumption was also that the MLWN may or may not be aware of her self-managing strategies or implicit knowledges. Further, my notions of self-managing strategies drew from Foucault’s (1988, 1994) perspective of the technologies of the self and self-surveillance as the self judging the self. Inherent within this notion was the MLWN’s enactment of values that reflected her vision to achieve goals, and development of strategies to survive and thrive in the work culture and care for her self.

**Phase 3. Critical Feminist Analysis of Realist Concepts**
The step-by-step approach I used to conduct a critical feminist analysis of the ethnographic data is presented below.

- I created a second Word document as a five-column table to accommodate the next steps to begin to address Objectives 1 (experiences), 2 (self-managing strategies), & 3 (power relations)
- Column 1: Realist Concepts
  - In column 1 I typed in all of the ‘Realist Data Topics’ that emerged from Phase 2 (as above). I then collated similar Topics to then form a new and different set of Realist Concepts. This list could also be
cross-checked against the Realist Data Topics and the original transcribed data of realist experiences.

**Researcher Assumptions:**
For the next steps in this analytic phase I viewed the participant’s realist data through a feminist oppression lens. Inherent in the realist exemplars I assumed the positively expressed experiences as empowering or transformative and the negatively expressed experiences as oppressive or disempowering for her. A critical feminist lens located the experiences as ‘states of being’, or subjectivity positions, and within fluid frames of empowering, transformative and disempowering and/or oppressive.

- Column 2: Positive Experiences integral to Self-Managing Strategies
  - I clustered similar ‘Realist Concepts’ which were positive experiences from column 1 and grouped these as tentative positive or empowering ‘states of being’ or subjectivity positions.

- Column 3: Empowering Experiences (Empowering Subjectivity Positions)
  - By reflexively thinking about the positive different ‘states of being’ I devised three terms that best reflected these grouped experiences and viewed these as empowering subjectivity positions:
    - Nurse Advocate – Passionate Connection
    - Patient Advocate – Prime Focus
    - Self – Different in the Moment
  - I further viewed these subjectivity positions as relating to personal, professional and/or corporate experiences depending upon my understanding of the impact the grouped-experiences had upon the MLWN.

- Column 4: Disempowering Experiences integral to Self-Managing Strategies
  - I clustered similar ‘Realist Concepts’ which were negative experiences from column 1 and grouped these as tentative negative or disempowering or oppressive ‘states of being’ or subjectivity positions.
- Column 5: Disempowering Experiences (Disempowering Subjectivity Positions)
  - By reflexively thinking about these negative different ‘states of being’ I devised terms that best reflected these grouped experiences and viewed these as disempowering or oppressive subjectivity positions:
    - Relationship with Nurse Executives – An Uninvited Voice
    - Government Employee – The Silenced Majority
    - Medical Dominated Unit – Unchallengeable Sovereignty
    - Professional Frustration – Fear for the Future of Nursing
  - I further viewed these subjectivity positions as relating to personal, professional and/or corporate experiences depending upon my consideration of the impact the grouped-experiences had upon the MLWN.

Emergent from this analytic phase was the first frame of insights:

1st Frame of Insights: Critical Feminist Analysis of Realist Concepts & Emergence of Multiple Subjectivity Positions.

Phase 4. Postmodern Foucauldian Analysis - Emergence of Discourses in the MLWN’s Cultural Context (objective 4)

The step-by-step approach I used to conduct a postmodern Foucauldian analysis of the ethnographic data is presented below.

- To address Objective 4 (discourses) I deeply reflected upon the data analysis to date. I also reviewed my understandings of Foucault’s (1980) postmodern power/knowledge notions as these potentially influenced the MLWN’s realist experiences, and thus, the emergent states of being as feminist subjectivity positions. From this position emerged the following analytic assumptions.

Researcher Assumptions:

I viewed the relationship between objectives 1, 2, & 3 as mutually linked and integral to the discourses (objective 4) within which the MLWN practiced. I attributed the meaning of discourse to that of
taken-for-granted common assumptions that framed the MLWN’s cultural context. My analytic lenses, to this point, included a focus upon the MLWN’s realist experiences and different forms of feminist states of being as subjectivity positions.

What became apparent from my critical reflective analysis about the MLWN’s analysis to date was an awareness of multiple discourses influencing the MLWN’s practice culture. My professional experiences and research review outcomes, as noted in chapter three, indicated the possibility of numerous different discourses within which the MLWN practised.

- From a Foucauldian (1980) perspective I viewed the cultural context of the MLWN’s experiences as an enmeshed always-present competing web of power/knowledge relationships. Three especially influential discourses were evident in the MLWN’s power/knowledge relationships. The three predominant discourses were:
  - Values Attributed to Nursing – Between a Rock and a Hard Place
  - Bureaucratic Managerialism – Absence of Care
  - Medical Science – Working the Margins

What was apparent to me was that the Values Attributed to Nursing Discourse was the predominant empowering discourse within which the MLWN endeavoured to function. However, there was conflicting and competing movement into and within two alternate patriarchally oppressive and dominant Discourses: Medical Science Discourse and Bureaucratic Managerialism Discourse.

- Having identified three predominantly influencing discourses I sought to double-check that within each of these discourses realist exemplar concepts could be located from the original transcriptions. Further, I re-checked that these could also be aligned with the various critical feminist subjectivity positions. This led me to phase 5 of the data analysis process.
Emergent from this fourth phase of data analysis was the second frame of insights:

2nd Frame of Insights: Postmodern Discourses Influencing the MLWN’s Cultural Context.

Phase 5. Alignment of Realist Exemplars against Emergent Postmodern Discourses (objectives 1-4).

The step-by-step approach I used to double-check alignment of the MLWN’s realist exemplars against the emergent postmodern discourses present in the MLWN’s cultural context is presented below.

- I created a new Word table with three columns to begin critiquing each Discourse. As an example, the following, Table 35. ‘Alignment of Realist Concepts against Emergent Discourses’ partially shows one discourse, Values Attributed to Nursing Discourse, and the three column table.

Table 35. Alignment of Realist Concepts against Emergent Discourses

<table>
<thead>
<tr>
<th>Discourse: Values Attributed to Nursing</th>
<th>Consistent with Dominant Discourse</th>
<th>Realist Exemplars: (Empowering; Transformative; Oppressive/Disempowering,)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Realist Concepts:</strong></td>
<td></td>
<td><strong>Empowering and/or Transformative Realist Exemplars:</strong></td>
</tr>
<tr>
<td>• Respect for humanity</td>
<td>Dominant discourse for nursing</td>
<td>• I am a pivotal person to try to make things happen on a daily</td>
</tr>
<tr>
<td>• Ethical practice</td>
<td>profession but subjugated by</td>
<td>basis.</td>
</tr>
<tr>
<td>• Passion for health &amp; wellness</td>
<td>medical discourse and managerialism</td>
<td>• I love my job, love my colleagues, and I love nursing.</td>
</tr>
<tr>
<td>• Respect for nursing knowledge &amp;</td>
<td>Not all of the values are positive, but are evident in this</td>
<td></td>
</tr>
<tr>
<td>practice</td>
<td>MLWN’s frame of practice.</td>
<td></td>
</tr>
<tr>
<td>• Role modeling</td>
<td></td>
<td><strong>Oppressive/Disempowering Realist Exemplars:</strong></td>
</tr>
<tr>
<td>• Mentoring</td>
<td></td>
<td>• Over-powerful medical dominant culture</td>
</tr>
<tr>
<td>• Wariness of expert nurses</td>
<td></td>
<td>• Takes on additional work</td>
</tr>
<tr>
<td>• Hard work will be rewarded/valued</td>
<td></td>
<td>• Works long hours</td>
</tr>
<tr>
<td>• Nurses do &amp; do not think – must be</td>
<td></td>
<td></td>
</tr>
<tr>
<td>seen to be active/busy at all times</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Column 1: Discourse
  - I typed in the name of the Discourse that framed the participant’s practice, e.g. Values Attributed to Nursing. Below this I listed related exemplar realist concepts from phase 2.

- Column 2: Dominant or Subjugated Discourse
  - I made a judgment whether this discourse was consistent with the taken-for-granted dominant patriarchal discourse or that of a marginalised or subjugated discourse (as identified from my literature and research review).

- Column 3: Exemplar Experiences
  - I located specific exemplar realist data from the MLWN’s original data which aligned with the respective discourse and grouped these according to my critical feminist analysis (from phase 3) under headings of ‘empowering’; ‘transformative’; or ‘oppressive/disempowering’.

- For the three emergent discourses I undertook the same process so that on completion I had developed three tables for this phase of analysis, that is: one table each for the Discourse of Values Attributed to Nursing, Bureaucratic Managerialism, and Medical Science. Within each table were the MLWN’s respective realist concepts and realist exemplars that had been revealed by critical feminist analysis as clusters of ‘empowering’, ‘transformative’ ‘oppressive/disempowering’ experiences.

- I reviewed this set of analytic documents which aligned the emergent three discourses with related realist concepts and realist exemplar experiences (as oppressive/disempowering, empowering or transformative). I also reviewed the documents I had previously created (phase 3) that aligned realist exemplars with different subjectivity positions. What was evident were links between the two sets of documents. I had, inadvertently, undertaken a cross-check for congruency and accuracy of realist data, subjectivity positions and discourses.

- By overlaying the subjectivity positions against the discourses in another Word table, below in Table 36. ‘Emergent Discourses & Subjectivity Positions’, I could confidently draw upon realist exemplars for each emergent respective discourse and subjectivity position and identify these as having been viewed as empowering, transformative, disempowering and/or
oppressive at the time of the analysis. The voices of the MLWN were integrated within the multi-lensed analytic processes.

Emergent from this phase of analysis was the third frame of insights. And is shown on Table 36. ‘Emergent Discourses and Subjectivity Positions’, below.

3rd Frame of Insights: Realist Concepts aligned against Feminist Subjectivity Positions and Postmodern Discourses
Table 36 Emergent Discourses and Subjectivity Positions

<table>
<thead>
<tr>
<th>Discourse</th>
<th>Empowering Subjectivity Positions</th>
<th>Disempowering Subjectivity Positions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Values Atributed to Nursing – Between a Rock &amp; a Hard Place</strong></td>
<td>Participant 4</td>
<td>Nurse advocate – passionate connection</td>
</tr>
<tr>
<td></td>
<td>Participant 3</td>
<td>Nurse advocate – passionate connection</td>
</tr>
<tr>
<td></td>
<td>Participant 1</td>
<td>Nurse advocate – passionate connection</td>
</tr>
<tr>
<td></td>
<td>Participant 2</td>
<td>Nurse advocate – passionate connection</td>
</tr>
<tr>
<td></td>
<td>Participant 5</td>
<td>Nurse advocate – passionate connection</td>
</tr>
<tr>
<td></td>
<td>Participant 7</td>
<td>Nurse advocate – passionate connection</td>
</tr>
<tr>
<td></td>
<td>Participant 6</td>
<td>Nurse advocate – passionate connection</td>
</tr>
<tr>
<td></td>
<td>Participant 8</td>
<td>Nurse advocate – passionate connection</td>
</tr>
<tr>
<td><strong>Patient advocate – prime focus</strong></td>
<td>Patient advocate – prime focus</td>
<td>Relationship with Nursing Executive - an invited voice</td>
</tr>
<tr>
<td><strong>Self - different in the moment</strong></td>
<td>Self - different in the moment</td>
<td>Relationship with Nursing Executive - an invited voice</td>
</tr>
<tr>
<td><strong>Relationship with Nursing Executive</strong></td>
<td>Relationship with Nursing Executive</td>
<td>Relationship with Nursing Executive - an uninvited voice</td>
</tr>
<tr>
<td><strong>Limited authority - marginalsed expert</strong></td>
<td>Limited authority - marginalsed expert</td>
<td>Relationship with Nursing Executive - an uninvited voice</td>
</tr>
<tr>
<td><strong>Medical Science – Working the Margins</strong></td>
<td>Medical dominated Unit - unchallengeable sovereignty</td>
<td>Relationship with Nursing Executive - an uninvited voice</td>
</tr>
</tbody>
</table>

**Disempowering Subjectivity Positions**

- Bureaucratic Managerialism – Absence of Care
- Professional frustration - fear of future loss of nurses
- Medical Science – Working the Margins
- Medical dominated Unit - unchallengeable sovereignty
- Limited authority - marginalsed expert
- Limited authority - fear of future loss of nurses
- Professional frustration - fear of future loss of nurses
- Medical dominated Unit - unchallengeable sovereignty
- Limited authority - fear of future loss of nurses
- Professional frustration - fear of future loss of nurses
Phase 6. Integrated Feminist Postmodern Analysis of Realist Experiences

The step-by-step approach I used to conduct an integrated feminist postmodern analysis upon the MLWN’s realist experiences is presented below.

- At the end of each Discourse Table (as per phase 4) I commenced another layer of analysis. The lens through which I approached the data was an integrated feminist postmodern lens. I sought to critique the realist data located within each revealed discourse using an adapted version of Lather’s (1991b:31) discourse analysis criteria inclusive of Foucault’s (1988, 1980) notions of power/knowledge relationships, technologies of self-surveillance and governmentality. Below is Table 37. ‘Feminist Postmodern Analytic Criteria Applied to the Ethnographic Data (adapted from Lather 1991b:30)’ which shows my adapted version of Lather’s feminist postmodern criteria.

- My aim was to disrupt the realist data and open it up for a different critique within a critical feminist oppression frame of reference integrated with postmodern Foucauldian perspectives. I also critically reflexively questioned the assumptions I was making about the emerging insights.

Table 37. Feminist Postmodern Analytic Criteria Applied to the Ethnographic Data (adapted from Lather 1991b:30)

<table>
<thead>
<tr>
<th>Analytic Criteria as Applied to the Ethnographic Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>- How does a feminist perspective inform This MLWN’s experience of this discourse? (gender, consciousness raising of oppression, emancipation, transformation, personal is political)</td>
</tr>
<tr>
<td>- How does This MLWN deal with issues of objectivity/subjectivity within this discourse?</td>
</tr>
<tr>
<td>- Does the discourse assume found or constructed worlds?</td>
</tr>
<tr>
<td>- What is left out?</td>
</tr>
<tr>
<td>- How does This MLWN resist and/or interrupt present power arrangements within this discourse?</td>
</tr>
</tbody>
</table>

- In first responding to each of Lather’s criteria against each of the three Discourses (as per phase 4) I also drew from the original transcriptions.
Researcher Assumptions:
From the data there were no specific indications that the MLWN’s choice of behaviour was informed by any specific form of critical reflection in practice. Her behaviour was informed by tacit expert experiential knowledge that she immediately drew upon to manage her different corporate, professional and personal experiences as evident in her complex role. In part, my assumption aligned with Patricia Benner’s (1984:31) seminal thesis of the expert performer, in that, ‘the expert performer no longer relies on an analytic principle (rule, guideline, maxim) to connect her or his understanding of the situation to an appropriate action’.

Further, in an unstructured manner, the MLWN may have been unconsciously drawing upon self-developed and established ‘emancipatory reflective’ skills (Taylor 2000:194) or well developed emotional intelligence (Freshwater & Stickley 2004; Glass 2007).

Hence, I drew upon Lather’s discourse analysis criteria because I believed that by responding to her questions, modified to focus upon the MLWN’s experience, I could reveal the self-managing strategies the MLWN used to deal with the various competing and always present discourses. Moreover, the always-present discourses influenced her states of being or subjectivity positions. The application of a postmodernist lens viewed subjectivity positions as mobile within which a person moved fluidly and at times simultaneously within more than one position.

This phase of analysis was a very troubling and time-consuming process as I needed to assure myself that I was authentic to the MLWN’s original data. I was not accustomed to this kind of feminist postmodern critique. For example, it took me some time to deeply appreciate the meaning and implications of the term ‘inscribe’ as used by Lather (1991b:30). This in-depth analytic process was empowering and transformative for me. My own level of consciousness-raising was being extended as I also deeply reflected upon my own nursing experiences and what Lather’s challenges meant to me.
What emerged from my critical responses to Lather’s analytic criteria, inclusive of postmodernist Foucauldian perspectives, was an exceptionally personalised and detailed critique for the MLWN’s experiences. This critique was against each of the three emergent discourses. What were revealed were previously unacknowledged insights. It was from this analytic perspective that the MLWN’s ‘unsaid’ (Glass 2003b:189) silences and invisibility became visible. The ordinariness of the MLWN’s taken-for-granted culturally constructed practice context was a reconstructed site of extraordinariness. The revealed insights for this MLWN were shown to disrupt and upend the notion that all nurses are oppressed equally and which aligned with Glass’ (2000) assertions that not all nurses are oppressed equally.

A multiplicity of local but personally politically resistive and productive self-managing practices revealed strategies the MLWN used to avoid patriarchal oppression and retain her empowerment. Her voices, revealed from this analysis, emerged as legitimate and valuable. This particular analytic integrated feminist postmodern lens applied to realist data also integrated a focus of the four research objectives: experience, self-managing strategies, power relations, and discourses.

Emergent from this analytic phase was the fourth frame of insights.

4th Frame of Insights:  Feminist Postmodern Critique of MLWN’s Realist Experiences

Critiqued insights emergent from one MLWN’s realist experiences against the Discourse Values Attributed to Nursing is presented below, as an exemplar in Table 38. ‘Phase 6 Exemplar - Integrated Feminist Postmodern Analysis of Realist Experiences’.
**Table 38. Phase 6 Exemplar - Integrated Feminist Postmodern Analysis of Realist Experiences**

<table>
<thead>
<tr>
<th>Integrated Feminist Postmodern Analytic Questions Related to the Realist Data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How does a feminist perspective inform this MLWN’s experience of this discourse?</strong></td>
</tr>
<tr>
<td>• This MLWN highlights that nursing &amp; nurses are oppressed and subjugated within the health arena at her local work level and at senior nursing level by the absence of interest/care by other health workers and at significant times by her executive nurses. Her feminist perspectives and pursuits of care, power equity, and reciprocal relationships are thwarted by many medical staff, AND by her executive nurses in a number of experiences she revealed.</td>
</tr>
<tr>
<td>• This MLWN is conscious of her submission to taking on additional work and that this is disempowering to her and adds to her frustrations about the oppressive nature of nursing work.</td>
</tr>
<tr>
<td>• This MLWN also experiences disempowerment in the need for nurses to persistently have to demonstrate their clinical expertise and knowledge as the means to gain recognition by doctors and executive nurses. Nurses always have to prove themselves worthy of attention and thus voice. Breaching the dominant medical taken-for-granted discourse is a momentary infiltration, but when the doctor’s change out the struggle begins all over again.</td>
</tr>
<tr>
<td><strong>How does this MLWN’s experiences reinscribe what it is resisting (medical science discourse)?</strong></td>
</tr>
<tr>
<td>• This MLWN demonstrated in her actions and conversation with me an unremitting commitment to the values of nursing in a consistent and passionate way. Rather than accepting the negative view of other’s about nursing’s contributions to the overall health outcomes for patients, This MLWN has reinscribed those negative perceptions/experiences into a passion for ‘speaking up’ and ‘speaking about’ nursing and nurses’ expertise on every occasion possible – she proactively pursues putting forward nursing and nurses’ value.</td>
</tr>
<tr>
<td>• At no time did I feel that I was overpowering this MLWN. I felt that this MLWN was very keen for me to be present with her, for her to have the opportunity to talk with someone who also held strong positive nursing values. I frequently acknowledged this MLWN’s expertise. Some of my questions challenged her comments and her reflective comments indicated acceptance on an equitable level.</td>
</tr>
<tr>
<td><strong>How is this MLWN influenced by unspoken norms and values within this discourse?</strong></td>
</tr>
<tr>
<td>• This MLWN’s passion and commitment to nursing values can be exemplified in her behaviour, tone of voice in the conversations we had, my observation of her in practice, her identified frustration of the way she and the nurses are so easily dismissed, uninformed, kept out of meetings etc. These exemplars indicate that there are key staff with whom she works that do not display those kinds of ‘nursing’ values which are also values of good citizenship and health professionals generally.</td>
</tr>
<tr>
<td><strong>How does this MLWN deal with issues of objectivity/subjectivity within this discourse?</strong></td>
</tr>
<tr>
<td>• Nursing values and knowledge closely align with feminist values which are subjugated and objectified as not scientific and therefore as illegitimate or common-sense opinions as perceived by doctors. Even this MLWN’s often reference to invisibility, lack of valuing, need to prove worthiness, lack of invitation to meetings, demonstrate an objectivity (lack of connectedness) perspective by her own executive nursing staff, and...</td>
</tr>
</tbody>
</table>
many doctors at her local level. A nurse’s subjectivity (acknowledgement of being an equal whose voice is valued) is recognised only when she has been exceptional in her practice and come to the attention of the doctors. The nurses are ‘bodies’ doing work that doctors do not understand or want to understand. The nurses are invisible.

- This MLWN retains a strong perspective of herself (subjectivity) and knows that she behaves differently with different groups with whom she works.

**Does the Discourse of Nursing assume found or constructed worlds?**

- Nursing values are constructed from historical perspectives of efforts to define/describe nursing’s worth, especially the concept of care for the patient. The values that this MLWN demonstrates are integral to her as a person which she has brought to her professional nursing interests.

**What is left out?**

- This MLWN’s recognition of her excellent skills, self-managing strategies, and the value she has to the Unit’s success on a daily basis.

- This MLWN also does not particularly recognise that her efforts to foster the valuing of nurses and nursing are political and that she is politically active whenever she challenges or resists the barriers that diminish nurses and nursing. She works from the boundary/margins to facilitate transformations among her nursing staff, doctors and her executive nurses. This MLWN thinks that the corporate politics is not what interests her and is a key factor in her reluctance to apply for more senior positions.

- The lack of recognition by nurse executives that the nurse’s voice is poorly acknowledged and valued in the work setting plus the high workloads of nurses are critical factors contributing to the high turnover of nurses and the poor attraction for nurses to be employed into certain work settings.

**How does this MLWN resist and/or interrupt present power arrangements within this discourse?**

- This MLWN chooses which battles to take on when nursing is being overlooked/dismissed etc. She works within the ‘Background’ medical dominated culture but keeps her sights on what will be best for nursing and nurses. She resists corporate nursing politics by not sitting in the front row at meetings, not engaging in some nursing meetings, rejects socializing as a political action to get close to executive nurses or those peers she does not respect; she initiates actions that will benefit patients at the expense of not being given credit for her initiatives, e.g. preparation of reports, policy development and implementation.

- Having completed this extensive level of analysis for the MLWN I believed my level of immersion of her data provided the wherewithal to further construct another two frames of pertinent insights. This level of deeper analysis is shown in phase 7, below.
Phase 7. Emergent Feminist Postmodern Insights of MLWN’s Self-Managing Strategies and Implicit Knowledges (objectives 1-4)

In this analytic phase I sought to construct a composite frame of insights which would be useful to the MLWN and potentially to a wider audience. The process I applied to construct this frame of self-managing insights is described below.

- The previous analytic phase, phase 6, critically reflected upon the MLWN’s realist data informed by Lather’s criteria and Foucault’s notions of power/knowledge, technologies of self-surveillance and governmentality. From deep reflection of these emergent insights, I believed there was an opportunity to more concisely make the analysis meaningful to the MLWN and to a wider audience. Thus, I developed an overarching frame of insights for this MLWN that aimed to succinctly reveal her self-managing strategies within the context of an integrated feminist postmodern analysis incorporating the four research objectives. I also drew from Foucault’s perspective of the subject as explained by Baker (1993:77), and as referred to in chapter four, as ‘an effect of the interplay of tactics and strategies on the power/knowledge network which produces self-knowledge from the multiplicity of possible subjections’. Also, as explored in chapter four, my notions of self-managing strategies aligned with Foucault’s (1988, 1994) technologies of self as self-government.

Emergent from this critical reflection was the fifth frame of insights. The details from this frame of insights is presented in the next chapter as inclusive of my discussion and critique of the emergent insights.

5th Frame of Insights: Insights of Feminist Postmodern MLWN’s Self-Managing Strategies

Flowing out of the frame of Insights of Feminist Postmodern MLWN’s Self-Managing Strategies were other notions that, in my analysis, related to implicit knowledge inherent in the MLWN’s self-managing strategies. This knowledge, I believed was unacknowledged but taken-for-granted and put into practice in different ways. These knowledge insights were not overt in our dialogue or my
participant observation. I was cognisant that these notions risked ‘essentialising’, or ‘speaking for’ the MLWN. However, I felt these knowledge notions were relevant to the MLWN and possibly common to each MLWN and, thus, needing to be explored.

This critical reflection revealed the sixth frame of insights. This frame of insights are also presented, in full, in the next chapter as inclusive of my discussion and critique of the emergent insights.


Phase 8. Draft Data Analysis - 2nd Member Check

Phase eight of data analysis represented a point for self-reflection. I had conducted an extensive multi-lensed analysis of one MLWN’s data. The steps that I took for this phase are described below.

➢ Before embarking on analysing the seven other MLWN’s data I again critically reflected upon what had emerged from the multiple analytic processes for the first MLWN. I questioned whether I had made assumptions in order to ‘fit snugly’ the insights from my analysis against the four research objectives. In particular, two questions vexed me:

Had I incorrectly juxtaposed the revealed subjectivity positions and related experiences into the discourses within which the participant practised?

What was the relationship between the participant’s subjectivity positions and the discourses in which they practised? Were some experiences or subjectivity positions fluid, fixed or simultaneously experienced within a discourse?
To my first challenge my cross-referencing technique provided me with a good level of comfort that I could confirm the first MLWN’s experiences aligned with my analysis. Of my second challenge I could also confirm the experiences were not fixed but were representative of the fluidity of the dynamic working reality of the MLWN.

Having applied the multi-phased process to one participant’s data I then commenced data analysis of the seven other individual MLWN’s data following the same phased approach in a similar manner.

For the subsequent analytic processes for each MLWN I found commonality and some uniquely different insights about their self-managing strategies. For example, for two MLWNs an additional empowering subjectivity position was revealed that related to ‘Relationship with Nurse Executive – An Invited Voice’. The individual MLWN’s revealed subjectivity positions are shown, above, in Table 36. ‘Emergent Discourses and Subjectivity Positions’. However, I considered the frame of implicit knowledge inherent and emergent from the first MLWN’s analysed self-managing strategies were common to each MLWN.

My research supervisors’ were encouraging about my data analysis approach and emergent insights. They indicated that I may have applied a unique method that effectively addressed the research question, aim and objectives and which directly aligned with my methodological premises.

I was satisfied with my assessment of the emergent draft frames of insights. I was confident that what had been revealed for each MLWN was valid, foregrounded the women nurses’ own voices, the insights were plausible and unique to each MLWN, and my analytic method aligned with the methodology and addressed the research question and objectives.

Subsequently, I telephoned the MLWNs to invite them to review my ‘preliminary’ draft analysis of their respective data. Six MLWNs with whom I was able to talk were excited at my progress and had thought about the study on many occasions. Our conversations were openly friendly and each was eager to talk about their experiences since last we had met. Two MLWNs were not able to be contacted for several months but their ensuing responses were also positive.
As a 2nd member check each of the eight MLWNs was sent their respective detailed preliminary analysis, inclusive of the documentation incorporating phases 1 - 7 data analysis, with a covering letter. Each MLWN was invited to review, comment, and/or change any part of the material but not delete any part of the documentation. I also sought further information, if they chose, about their experiences and the research.

Seven participants replied to me by email and one by telephone. Their reflective comments were subsequently incorporated into my discussion in chapter six. Each participant agreed with the preliminary analysis pertaining to them. They acknowledged that they had ‘moved on’ from their experiences at the time of the ethnography. However they also acknowledged that the analysis fitted with that ‘slice-in-time’.

Most MLWNs found the data analysis document difficult to follow because of the complexity of the methodological perspective I had used. However, no changes were requested. Their respective comments are included in chapter six as integral to the discussion of the emergent insights.

The outcome of the above analytical activities meant that I had created an enormous volume of words from each participant’s data. There may have been alternate ways to undertake this analysis, but it was my way of self-immersing in their individual data and keeping focused on the methodological perspectives. Having gained deep appreciation for one participant at a time meant that the insights that emerged were specifically personal but with considerable commonality but not an overall generalised opinion.

**Phase 9. Preparation for Discussion - Chapter 6. The Voices of MLWNs’ Experience & 3rd Member Check**

Phase 9 of the analytic process focused upon the steps taken to gain a 3rd member check from each MLWN. This was an important stage of the research process, further supporting my research validity and authenticity, trustworthiness, and my promise to protect the MLWNs’ identity. The steps for this phase are explained below.
In preparing chapter six, The Voices of MLWNs’ Experiences, my interest was to incorporate discussion of the emergent insights as well as selections of each MLWN’s realist data. In order to affirm that the MLWNs’ identities and place of employment were protected I mailed to each MLWN those parts of their transcribed conversation that I aimed to include. This formed my 3rd member check with the research participants.

Each MLWN expressed gratitude that I had respected their need for anonymity and only minor changes were requested by two MLWNs.

The feedback from the MLWNs completed the analytic phase of this ethnography. However, in preparing chapter six, my multiple methodological lenses were refocused upon myself, as a method to inform my critique and discussion of the emergent insights and understandings of the MLWNs’ experiences.

Summary of Trifocal Methods and Researcher Assumptions

An integrated feminist postmodern ethnographic methodology and method is a recent research genre within the nursing practice research arena. There was considerable literature that explored and critiqued the underpinning philosophical premises, particularly its potential for consciousness-raising and partial emancipation for research participants from oppression. There was a plethora of literature that explored and described analytical strategies for ethnographic data that was informed by critical qualitative theories and premises. However, no literature were found that prescribed the ‘how to analyse’ process suitable for the integrated methodological premises and the focus of my research question and objectives. Glass and Davis’ (1998, 2004) feminist postmodern ethnographic frame that informed my methodology also influenced my approach for a trifocal analytic process. My options were opened up to create a unique analytic process that might effectively achieve my ontological, epistemological, philosophical and practical interests for the research.

My principal research interest was to keep close to the MLWNs’ reality experiences of practicing within the cultural context of public hospitals in WA. I viewed the ethnographic period as a ‘slice-in-time’ of their practice world but was cognisant
that their history was always present. The experiences each MLWN revealed was not simply representative of the immediacy of their day-to-day practice, their stories encompassed their private and undisclosed history and tacit knowledge as women and nurses. Nor did I view my participant observations, field notes and critical journal reflections as representative of the totality of my ethnographic experience with each MLWN, my history and knowledge were also ever-present and I was reflexively and intimately interconnected and integral to the research.

The data analysis methods that evolved for me was created out of my deep immersion in trying to retain the integrity of the research aim and objectives contextualised within my methodological premises while reflexively questioning the obvious and the non-apparent data of each MLWN.

I believed the research question, aim and the four objectives were intergrally interconnected and from which multiple layers of depth and breadth of insights might have emerged that would contribute to the body of nursing professional knowledge. More importantly, I believed there was an untapped resevoir of knowledge implicit within each MLWN that needed to be revealed, foregrounded, validated and celebrated to themselves and to the wider nursing professional community. Whether the revealing of my research insights have a feminists’ liberatory or transformational effect for each MLWN was not ascertained.

Multiple levels of data analysis emerged as appropriate to address the research question, aim and objectives with the MLWN’s individual data. Following the first phase of authenticating each MLWN’s transcribed critical conversation, the second level applied a realist analysis method. The second level also drew from critical feminist perspectives from which the MLWN’s experiences were viewed within the oppression narrative context. Foucault’s postmodern notions of discourse informed the third level of analyses from which three ‘always present’ and competing discourses were revealed. The fourth level of analysis extended out of the third level of analysis in which the emergent MLWN’s subjectivity positions were aligned against the respective discourses. The fifth level of analysis deeply and extensively critiqued the data applying Lather’s (1991b) specific feminist poststructural
(postmodern) discourse analysis criteria and with Foucault’s (1980) power/knowledge relations, self-surveillance and governmentality notions. From this level of analysis emerged a summary of integrated feminist postmodern insights and a set of implicit knowledge insights for each MLWN. The integrated feminist postmodern insights encompassed commonalities among the MLWNs’ experiences but with unique differences in some areas, whereas the implicit knowledge insights were embedded within each MLWN.

The analytic process incorporated three member checks that aimed to authenticate original realist data, relevance, credibility and validity of emergent individual data analysis, and assure the protection of each MLWN’s identity and their respective employing hospital. Validating the uniqueness of each MLWN’s experience was the prominent premise in my analytical process.

I applied multiple member checks at different analytical phases to retain the integrity of the feminist premise of researcher-researched reflexivity and of endeavouring to conduct research with the MLWN and not on her. Further, I aimed to avoid collapsing into a modernist’s authorial approach. Multiple member checks also fostered an audit trail, authenticity, credibility and trustworthyness. In addition, as is evident in the next chapter, the inclusion of ‘excerpts of actual dialogue between researcher and participants, as sources of data aimed to assist in validating interpretations and to act as a decision trail for readers’ (Roberts & Taylor 2002b:497).

In my endeavour to be open and transparent, in keeping with feminist research principles, the following Table 39. ‘Researcher Assumptions Underpinning the Research’, also comprised my assumptions that influenced my research perspective.
Table 39. Researcher Assumptions Underpinning the Research

<table>
<thead>
<tr>
<th>Assumptions that Underpinned the Research</th>
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<tbody>
<tr>
<td>▪ My view of reality, knowledge and truth is not static, but evolving and constantly challenged. There are multiple realities rather than a unified truth. Knowledge is local, contextual and socially constructed.</td>
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<tr>
<td>▪ The integration of modern feminism (critical social science) and postmodern (affirmative) principles are suitable for nursing research. The integration draws together the features that:</td>
</tr>
<tr>
<td>▪ Not all women or nurses are oppressed and dis-empowered equally. Nursing comprises a multitude of individuals, mostly women, who bring to their everyday working world values that emanate, for example, from their private, family, professional, organisational and global social constructs and experiences.</td>
</tr>
<tr>
<td>▪ The organisational culture within which women nurses practise is politically and socially constructed.</td>
</tr>
<tr>
<td>▪ Nursing has been constructed by medical and male gender discourses and is reflective of society’s dominant ideologies.</td>
</tr>
<tr>
<td>▪ The middle-level nurse’s role is complex.</td>
</tr>
<tr>
<td>▪ Middle-level nurses, who are predominantly female, by the nature of their span of work control practice in isolation with peers and as such this identifies them as a marginalised group with a unique cultural identity within the larger organisational culture.</td>
</tr>
<tr>
<td>▪ Individuals and their experiences are different and unique.</td>
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<tr>
<td>▪ Consciousness-raising, empowerment, emancipation, and social transformation begin with the individual, not necessarily the group.</td>
</tr>
<tr>
<td>▪ Consciousness-raising occurs throughout the whole research process, not at the conclusion in that empowering transformations may occur from the mutual sharing, analysis of and reflection upon knowledge and experience.</td>
</tr>
<tr>
<td>▪ Practice based experiential nursing knowledge is unique and contributes significantly to the body of professional nursing knowledge.</td>
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In the next chapter the emergent insights from the innovative multi-phased data analytic method are presented and discussed. In some ways the next chapter aims to unravel the complexity of my method. Having partially deconstructed the MLWNs’ experiences as a method to reveal hidden and unacknowledged insights and knowledge, my aim in chapter six is to reconstruct these methodologically constructed insights within the context of the MLWNs’ reality experiences. Their reality, as their multiple voices, will be integrated with the emergent insights. The emergent meanings, from my researcher perspective, forms the basis of discussion in the next chapter.
However, the principal meanings emergent from this research related to the individualised data analysis of each MLWN’s ethnographic data and their acknowledgement of its authenticity. The multiple member checks centred them as women and nurses and producers of knowledge at a deeply personal level. The revealed implicit and tacit knowledge of their self-managing skills within the complex patriarchally dominant cultural construction of the WA public hospitals was valuable and worthy of celebration. Their experiences were explored to reveal their ‘unsaid’ (Glass 2003b:189) and to create a forum for them to be ‘de-silenced’ (Glass 1998:125) in unique but pertinent ways to them.
Chapter 6.
The Voices of Middle-Level Women Nurses
Introduction

The ethnographic data of the MLWNs’ experiences were fragments of their dynamic reality. As such, these were partial representations of their total lived experiences and their choice of what aspects of their reality they revealed. An integral feature of the ethnography was to valorise the MLWNs’ knowledge inherent in their experiences. This aim sought to reveal what it meant for each MLWN to enact the multiplicity of competing and complimentary roles and responsibilities inherent in their corporate and nursing professional job. The research process aimed to provide a safe forum for the MLWNs to move from silenced to de-silenced (Glass 1997, 1998, 2001b; Johns 1999). The research intent was to view each MLWN’s raw data through particular methodological lenses. My aim was to reveal meaning, beyond that of their realist experiences and ‘in ways which do not disemboby and disconnect voices and ideas from the women involved’ (Glass 2002-2003:51). It was therefore the intention, acknowledging my ‘epistemic privilege’ (Aranda 2006:frame 5), to shed new and/or different insights into the participants’ experiences of being middle level women nurses. The MLWNs’ experiences, whilst unique to them, may resonate as similar experiences for other nurses who hold middle-level positions, yet in no way can they be claimed as generalisable.

Detailed in the previous chapter was the multi-phased methods I used to analyse the ethnographic data. I applied a trifocal analytic lens to the data: realist, feminist and feminist postmodern, from which six different but inter-related frames of insights for the MLWNs were revealed. In this chapter I present a structured critical discussion of the analysed data linked with selections of related realist data from the MLWN’s critical conversations and my critical reflections journalled as participant observations and field notes.

This chapter is not intended to be a straightforward academic reading or to present conclusive, fixed or singular meanings. Multiple and alternate understandings may be read of the work presented. It was my choice to apply an integrated feminist postmodern lens as a method to investigate the MLWNs’ realist experiences to reveal emergent insights. In so doing, I appreciate that I may also have committed
unintended domination by privileging my role as researcher, facilitator of meaning-making and author (Lather 1991c:ix). For example, I am conscious that it was my choice to select which MLWN’s experiences to present and which I avoided disclosing. However, such decisions were ethical in intent and action in that it was those reflections that were so deeply private or those that identified the participant or hospital and were avoided. Further, ‘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’ (Ogle 2004:192).

My intent in this chapter is severalfold. Firstly, to reveal the eight women nurse participants as real ‘people’, that is as women and nurses. This was not to presume these were their only identities, but rather, as reflective of their multiplicity of identities. Secondly, the focus of this chapter specifically centres the MLWNs’ sociopolitical, different, unique, local, historical, contextual, multiple and mobile realities of practicing within the WA culture and structure of metropolitan public hospitals. Thirdly, the discussion in this chapter is political in three ways.

The first political intent of this chapter is to make overt ‘how power permeates the construction and legitimation of knowledge’ (Lather 1991c:xvii) in a way that uncovers the MLWNs’ mostly unconscious every-day taken-for-granted social construction of patriarchal oppression. Secondly, by considering the premise that the interconnected personal, professional, and corporate functions of each MLWN’s work role were politically intertwined and enacted within the dominant patriarchal cultural context that subjugated nursing and nursing knowledge. Thirdly, by taking away the barriers so that each MLWN speaks for herself of her understandings of her situations (Lather 1991b). By removing barriers also fostered the revealing of individual and collective implicit knowledge. This chapter is a professionally political forum for valorising and legitimating the MLWNs’ personal and professional knowledge and publicly revealing their ‘unsaid’s’ (Glass 2003b:189) whilst protecting their private identity.
What is revealed in this chapter are MLWNs’ experiences that ranged across and between being understood as disempowering/oppressive and/or empowering subjectivity positions. Also presented is the repertoire of MLWNs’ self-managing strategies they used within their multiple subjectivity positions to fluidly move in and around the network of power/knowledge relationships present in the different discourses. These discourses particularly influenced the cultural context of their day-to-day practice. Their self-managing strategies were examples of how they endeavoured to productively re-inscribe their preferred discourse of nursing values. They were also examples of how they resisted being inscribed by the power/knowledge relationships present in the dominating discourses. By viewing the MLWNs’ experiences through an integrated feminist postmodern lens the analysis revealed the variously different and unique ways that the MLWNs ‘interrupt relations of dominance and subordination’ (Lather 1991c:xvii) and which had liberatory potential integral to their day-to-day lived practice. The research question, focus, aim and objectives were embedded in the process.

Every experience disclosed by the women was analytically viewed to have feminist political motives intrinsically embedded. Although, initially the MLWNs were not consciously aware of the extent of their feminist political activism. However, this became more evident as the deepening layers of analysis found expression of meaning in different ways. What emerged was that whenever the MLWNs demonstrated the valuing of nurses, nursing and patient care they were politically challenging or resisting hegemonic discourses. They confronted or worked the margins in an effort to transform that which they tacitly knew to be oppressive or disempowering for nurses, patients and themselves. Their efforts endeavoured to uphold, affirm and inscribe the values and valuing of nursing and nursing knowledge as legitimate social constructions. This was aimed to compliment other health professionals’ and hospital administrators’ ways of being that as a collaborative team could achieve the best health outcomes for patients.

The constant interplay of the web of power relations (Foucault 1980) inherent in the MLWNs living within the intersecting and different discourses influenced their different subjectivity positions. These were not clear-cut either/or dualistic positions.
rather they were multiple, mobile and alternate ways of being. Further, their subjectivity positions were viewed as unfixed or fluid. They were simultaneously experienced as oppressive, disempowering, emancipatory, empowering and/or transformative. The MLWNs’ intrinsic self-knowledge was assumed to influence her self-managing strategies. The sociopolitical construction of the culture within which the MLWNs practised was identified by the hegemonic and predominantly disempowering discourses of bureaucratic managerialism and medical science. This experience contrasted with their preferred empowering, albeit marginalised, discourse of values attributed to nursing.

Each MLWN’s affirmations of the various emergent ethnographic insights, not as truth but as insights that resonated with them, was a principal aspect of the feminist political interest for me as the researcher. My efforts to foster a research relationship of trusting reflexivity and reciprocity with each participant, thus, sought to create a collaborative research process with them but not on them. Also, included in this chapter are some of my self-reflexive comments/insights as participant observer and exemplar experiences that pertained to the MLWNs’ experiences.

Chapter five detailed the analytic process applied to reveal six frames of insights. These emerged from the integrated feminist postmodern multifocal analysis of ethnographic data focused upon the research question and specifically upon the research aim and objectives. Each MLWN engaged in reflecting and commenting upon, in a semi-collaborative consciousness-raising approach, each of these various insights. My multiple levels of engagement with each MLWN aimed to facilitate the MLWN’s revealing previously unacknowledged tacit self-knowledge that related to her ways of being within the context of the multidimensional socially constructed power relationships.

In considering an appropriate way to structure this chapter I believed it was important to organise it into four sections as a way to foster a convenient flow for reading. However, the sections do not represent segregated or stand-alone
information. Inherent in each section is reference to the research question, aims and four objectives.

The first section presents the final two frames of insights that emerged from data analysis: The MLWNs’ Self-Managing Insights and Implicit Knowledge Insights. These two frames of insights emerged from my critical feminist and feminist postmodern data analytic processes. These were two of the three methodological lenses through which I viewed the MLWNs’ individual and collective meanings of their realist data. The four research objectives were inherently addressed within these frames of insights.

Sections two, three and four reflect the three particular emergent discourses and respective subjectivity positions. These relate to the MLWNs’ ways of being within the sociopolitical context of their day-to-day practice. I connect my critical discussion about each discourse and respective subjectivity positions with selected pertinent MLWNs’ realist data. Subheadings are used to support some subjectivity positions to assist the appreciation of the plural nature of the MLWNs’ realist exemplars.

Many of the MLWNs’ exemplar realist experiences presented in this chapter could have been located in several different subjectivity positions. The positions inherently encompassed the fluid nature of the power/knowledge inter-relationship networks of the MLWN, and therefore, the experiences could have encompassed more than one subjectivity position. To exemplify this fluidity some experiences located within the disempowering subjectivity position of Relationship with Nurse Executives (e.g. ‘the money value is philosophically problematic’) could also have been positioned in the empowering Nurse Advocate (e.g. ‘empowering management style’) or Patient Advocate subjectivity positions. My effort to show the MLWNs’ fluidity of movement within subjectivity positions was pictorially impossible and would require a multidimensional in-constant motion model.

In the summation for this chapter I develop a lead-in to the final chapter in which the implications of this research are explored and consideration for future research
is discussed. In the final chapter I also provide some reflections about my journey through this research.

Where dialogue is presented between the participant and myself I use the MLWN’s pseudonym and my first name, Helen. When I include exemplars from my experience or reflections from my field notes or journal I also use my first name. Where I believe the identity of the participant is at risk I refer to her in the generic title of MLWN. Also throughout this chapter I apply *Times New Roman* as the style to highlight the realist voices of the MLWNs and myself and also to the insights revealed from data analysis.

The pseudonyms I selected for the MLWNs were: *Celia, Chloe, Brigit, Holly, Jasmine, Kara, Misha, and Poppy*.

The following, section one, presents two frames of insights emergent from the trifocal ethnographic data analysis. These insights are presented as a collective of the MLWNs’ data analysis with inclusion of individual MLWN’s insights where these diverged from the collective notions. These insights provide a different and unique methodological view of the realist lived experiences of the MLWNs that are presented in subsequent sections.

**Section 1. Self-Managing Strategies and Implicit Knowledge**

**Introduction to this section**

The interconnection of analysis of the research question, aim and four objectives with the ethnographic data is exemplified in two frames of insights that emerged from the multiple levels of phases 1 – 5 of data analysis informed by realist, critical feminist, and feminist postmodern perspectives (please refer to chapter five for details of the process). The first frame of insights is presented below in Table 40. ‘Emergent Feminist Postmodern Insights of MLWNs’ Self-Managing Strategies’.
Table 40. Emergent Feminist Postmodern Insights of MLWNs’ Self-Managing Strategies

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<tr>
<th>Emergent Feminist Postmodern Insights of MLWNs’ Self-Managing Strategies</th>
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<tr>
<td>▪ What I perceived emerged from undertaking the ‘reality’ analysis of various MLWNs’ experiences was an understanding that these were potentially positive or negative. Further, through a critical feminist lens it was revealed the experiences could be viewed as oppressive/disempowering, emancipatory, empowering, and/or transformative experiences, as possible ‘subjectivity positions’/‘states of being’ within which were the MLWNs’ self-managing strategies. Their self-managing strategies could be acknowledged as high emotional intelligence (Glass 2007) as their ways of critically reflectively analysing how to behave within the situation, or future situations, to facilitate the achievement of their goals. Integral to their changing subjectivity positions was their internal resilience capacity which in turn reaffirmed their self-confidence.</td>
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<tr>
<td>▪ Experiences which the MLWNs’ identified as being positive were also identified as empowering and motivating. The MLWNs’ revealed empowering and motivating kinds of experiences fostered their self-confidence and passion; inspired them to keep in the job and to go into battle on behalf of nurses, nursing and good patient outcomes.</td>
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<tr>
<td>▪ It was each MLWN’s connection with her nursing professional responsibilities and with her selected peers which predominated as empowering and transformative experiences. There were few experiences related to most MLWNs’ corporate responsibilities that they experienced as empowering. However, two MLWNs had slightly differing experiences. One MLWN’s high level of respect accorded her by both medical specialists and nursing executives predominately resulted in empowering and transformative experiences. Another MLWN also experienced her relationship with Nursing Executives, whilst primarily empowering, some aspects were disempowering. These two MLWNs’ ‘voices’ were respected and acknowledged as valid and integral to the directions of nursing practice within the hospital. Thus, their focus to ‘be heard’ in respect to corporate issues for nursing and patient care was high.</td>
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<tr>
<td>▪ If each MLWN’s self-confidence and passion was high, the negative (oppressive/disempowering) experiences became motivators to act more assertively to change by ‘speaking up’ or ‘letting it go’, these were also self-managing strategies.</td>
</tr>
<tr>
<td>▪ When there was neutral balance between empowering and disempowering experiences or the balance was more toward empowering experiences then each MLWN was also confident in her work and her capacity to achieve her goals.</td>
</tr>
<tr>
<td>▪ In contrast, if negative experiences persisted to outweigh positive experiences then the MLWN knew she would experience symptoms of burnout; in particular her self-confidence and resilience-capacity would be markedly diminished. One strategy that each MLWN used to regain her self-confidence in the face of oppressive/disempowering experiences was to retreat to concentrate on those areas of her work which she found to be empowering.</td>
</tr>
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</table>
Emergent Feminist Postmodern Insights of MLWNs’ Self-Managing Strategies

- For the majority, the MLWNs’ exemplar experiences showed those experiences which most negatively impacted upon them related to the corporate aspects of their work; aspects of their relationships with their nurse executives or doctors. For these MLWNs, the absence of reflexive empowering dialogue with their nurse executives, in particular, indicated a power-differential that further created a distancing in their connection with corporate components of their work. Thus, their focus to ‘be heard’ in respect to corporate issues for nursing and patient care became limited. However, one MLWN had empowering experiences with both these groups of senior staff. Whereas, another MLWN’s exemplar experiences showed the experiences that most negatively impacted upon her related to the oppressive or disrespectful situations she noticed that occurred for some nurses by some doctors. One MLWN also experienced high disempowerment in relationship with the DoHWA’s lack of caring and interest in the way the Department implemented hospital executive restructuring especially as this related to nursing senior/executive positions without any regard for the negative impact upon the leadership of nursing.

- Each MLWN was not aware that she moved in and between different self-managing strategies (strategies to deal with the different power-relationships relating to her nursing professional and corporate responsibilities) as she went about her work. In my perspective each MLWN was constantly using an array of self-managing strategies which interplayed between past experiences or a decision to deliberately trial a new strategy.

- There was a ‘web’ of power relations in constant play for each MLWN. She mentally positioned herself in each interaction. Each MLWN’s self-knowledge of the power-relationships that were present influenced her self-managing strategies and thus her behaviour. The changes in her behaviour were directed to heightening her self-confidence. This was evidenced by her repertoire of self-managing strategies, in order to more effectively achieve her goals as both a nurse advocate and patient advocate. Those self-managing strategies were also political endeavours, that were integral to her principal purpose for being in the job. Her efforts were not self-serving but rather aimed to influence, by confrontation or working the margins, those who assumed the power to make decisions and to have them ‘hear the voice of nursing and patients’. Each MLWN’s efforts, unconsciously, were to make ‘the personal political’ – she was the political conduit through which the ‘silenced’ might be heard.

- What also emerged was that each MLWN was not openly resistive to the oppressively dominant cultural discourses in which she practised, behaviour that she knew would instantly and irrevocably isolate her from any future success in being ‘heard’. Such a circumstance heightened her awareness to the possibility of being ‘manoeuvered out’ of the job and could mean the ‘death’ of her motivation to stay in the job.

- Further, from considering these possible ‘subjectivity positions’ there emerged three competing discourses, taken-for-granted assumptions of the culture in which each MLWN practised and within which I perceived each MLWN moved in her work. These discourses were discrete but easily identifiable upon close analysis and seemed more like a mixing of different miasma in practice. The discourses were externally socially
Emergent Feminist Postmodern Insights of MLWNs’ Self-Managing Strategies

constructed yet internally embedded and continuously in-conflict with each MLWN’s personal value set and her multiple self-identities inclusive of her identity as a woman, nurse, and middle-level manager/clinical specialist. Inherent in each discourse was the apparentness of the power/knowledge relationship constructs. Where one person may have been functioning within one discourse another person in that relationship may have been functioning, unknowingly, within a different and competing discourse. The complexity of such experiences, it seemed, would create confusion and barriers between the parties and the risk of not being ‘heard’. Further, the various experiences which showed a lack of connection by the nurse executives with most MLWNs may be a cultivated culture of effort to keep staff like many MLWNs silent. The situation could be likened to a servant whose voice was unheard because it challenged the power base or knowledge of the master, or the oppressor oppressing their own group members.

- Each MLWN’s predominant and preferred internal discourse was toward her nursing values. This contrasted with an alternate and dominant discourse for many of the doctors with whom the MLWN worked and within which it seemed most of their nurse executives functioned.

- The two alternate dominant discourses emerged from analysing each MLWN experiences and related to the traditionally medical scientific culture and the bureaucratic managerialist discourse, both patriarchal and oppressive to the nursing values discourse. It was within the MLWNs’ embedded nursing values discourse that the majority of their empowering and transformative experiences could be located. On the other hand, the more oppressive/disempowering experiences were located in one or both of the more traditionally dominant discourses.

- The repertoire of most MLWNs’ self-managing strategies incorporated a further complexity in regards to their emancipatory interests for nurses and patients within their scope of responsibilities. The dominant oppressive discourses restricted the frame of influence to their local unit level. However, this was different to two MLWNs whose influencing frame extended into the higher political levels of the hospitals such as within nursing executive realm. This was exemplified by the all too often lip service paid by those in authoritative and dominant positions to patients and nurses.

- Each MLWN also worked against the oppressive discourses. They did this both in resistive and productive ways, in order to influence change by disrupting the oppressive discourses. They used deliberated confrontation as well as creep in/up strategies to breach the opposing dominant discourses so that the ‘voice of nurses and patients’ could become inscribed as integral taken-for-granted considerations by those who typically function within those oppressive discourses.

- The Discourse of Nursing Values imbibed a philosophy of caring for the whole person who was not able to independently self-care – nursing functions that supported the individual in the process of wellness, illness, healing, or death. In contrast the Discourse of Medical Science within a hospital was about cure of disease. Foucault’s (1973) exploration of the ‘The birth of the clinic’ announces historical clarity about the medical purpose of the establishment of the modern hospital within the context of
modern clinical medicine in France since the seventeenth century. The medical gaze was toward the scientific process of collecting the subjective symptoms of disease, collating and analysing these within the aggregate of objective signs of disease, and calculating the treatment to resolve the disease. It was in the region of ‘subjective symptoms that - for the doctor - defines not the mode of knowledge, but the world of objects to be known’ (Foucault 1973:x). Whereas, the nursing gaze was focused toward the patient’s subjective symptoms and supporting the patient in managing those symptoms; as well as monitoring, on behalf of the doctor, the signs of disease (Chiarella 1998). Foucault’s technology of governmentality (Foucault 1979 In Cheek 2000:27; Gordon 1991) could be linked with the alternate but predominating Bureaucratic Managerialist Discourse of the hospitals’ corporate agenda of cost efficiency and constraints, policies and consenting subjugated work practice rules. Bureaucratic Managerialism negatively impacted upon the values and desired focus of practice for the MLWNs.

- The MLWN’s self-confidence was embedded in her values, those crucial ethical principles that constituted her soul. When her soul was in harmony she knew she was being ethical: to herself and those for whom she ‘speaks’ on their behalf. From a Foucauldian (1997:230) interpretation of Plato she was ‘caring for [her]self’.

- Each MLWN’s interpersonal relationships were influenced by a number of factors, including but not exclusive of: 1. the personality of the person: whether, or not, their values were inherently valuing toward other people; 2. the assumptions the person held about their position power: whether, or not, they practised from an empowering non-hierarchical respectful stance; 3. the dominant discourse within which they practised: whether, or not, the discourse was complimentary to their professional agenda or the agenda of another, e.g. that of Nurse Executives who may, deliberately or inadvertently, have practised predominantly within the discourse of bureaucratic managerialism.

The following represented realist examples of each MLWN’s transformative experience constructed within a productive political action:
**MLWN Participant** | **Exemplar Transformative Experiences:**
---|---
**Celia:** | Celia’s transformative experience was when she positively influenced the senior doctors and Nursing Executive’s attitudes toward patients in mental health crises who need to be more considerately, respectfully and safely managed.
**Chloe:** | Chloe’s transformative effort was evident in a nursing team’s development of a Patient Education Pamphlet and, in part, aimed to influence the senior doctors and Nursing Executive’s appreciation of nurses’ expert knowledge.
**Holly:** | Holly’s transformative efforts were evident in her collaborative discussions and planning with specialist doctors in the development of a specialty nursing course and the associated business proposal that aimed to influence the Nursing Executive’s appreciation of nurses’ expert knowledge and need to fund the course.
**Brigit:** | Brigit used her expert clinical experience and her engaging and assertive personality to effect change by influencing senior doctors and Nursing Executive in matters related to the contribution nurses make to Best Practice in patient care.
**Jasmine:** | Jasmine’s transformative experience concerned influencing the nature and extent of professional development for newly employed nurses.
**Kara:** | Kara’s transformative experiences focused on the changed behaviour of nurses she taught to enhance their clinical practice; positively influencing doctors’ opinion and respect for nursing knowledge.
**Misha:** | Misha persisted in keeping the ‘nurses’ presence’ on the agenda with both her Nursing Executives and that of doctors as well as her struggle to gain acknowledgement of the need for a specialty nursing course.
**Poppy:** | Poppy persisted in finding ways to have her ‘voice’ heard by Nursing Executives even at the expense to her own health. Her mentoring of nurses was critical to retaining self-confidence and fostering her self-worth.

From phases 1 - 5 levels of analysis emerged nine common points that I viewed related to implicit knowledge inherent in the MLWNs’ respective self-managing strategies. These points of implicit knowledge, I believed, were unconscious and therefore unacknowledged but taken-for-granted. Table 41. ‘Emergent Implicit Knowledge’ presents these insights.
Table 41. Emergent Implicit Knowledge

<table>
<thead>
<tr>
<th>Emergent knowledge pertinent to each MLWN:</th>
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<tbody>
<tr>
<td>1. Knowing her own worth; believing in her values; acceptance of herself as a person, woman, nurse, expert, learner.</td>
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<tr>
<td>2. Knowing she ‘can do’; prepared to take personal risks; persistent in the face of defeat; sets and achieves own goals; self-critical &amp; self-rewarding; self-motivating; active change-initiator/mentor.</td>
</tr>
<tr>
<td>3. Knowing she has like-minded colleagues with similar values; reciprocity in friendships; egalitarian power relationships with like-minded nurses and other health workers or professionals; transparent, open vulnerability in communications with like-minded colleagues; validated &amp; affirmed as a person to respect; mutual facilitation in learning how to be better in her role.</td>
</tr>
<tr>
<td>4. Knowing what situations (power/knowledge relationships: empowering, transformative, oppressive/disempowering) she will/will not have her voice ‘heard’ (the personal is the political – she is politically savvy at the local level); how to behave/communicate to foster her voice being ‘heard’ (working face-on or from the margins); prepared to try different behaviours/communication styles when her voice is ‘not heard’ ( creep-in/up strategies to impact upon the Background culture).</td>
</tr>
<tr>
<td>5. Knowing she functions within a taken-for-granted culture in which nurses are poorly valued, misunderstood, rejected as experts; financial cost-saving is at the expense of best patient care; some nurses actively undermine/bully nurses (the oppressed oppressing the oppressed); and actively resists this negative taken-for-granted culture to practice an empowering, tolerant and ethical style of management.</td>
</tr>
<tr>
<td>6. Knowing her principal focus is toward best practice for patient care (professional connection) and this parallels her focus toward the best environment (culture) for the nurses to practise their expertise.</td>
</tr>
<tr>
<td>7. Knowing when she is vulnerable to being devalued and the possible fracturing of her self-confidence; can mobilize self-protective mechanisms.</td>
</tr>
<tr>
<td>8. Knowing that she differentiates in her actions and allegiance between her corporate managerial responsibilities and her nursing professional values which have a direct connection with best nursing practice in patient care.</td>
</tr>
<tr>
<td>9. Collectively, these kinds of knowledges are apparent as a consequence of self-reflexivity – self-analysis or contemplative soul searching. Self-reflection may be viewed as an internal voice giving logical or reasonable consideration to her ethics.</td>
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</tbody>
</table>
The MLWNs’ individual affirmations of these insights, as meaningful to her, as related to the their ethnographic ‘slice-in-time’ experiences are presented below in Table 42. ‘MLWNs’ Comments from Review of Analysis and Emergent Insights’. These comments were received in writing from six MLWNs after they reviewed their respective preliminary analysis and emergent insights pertinent to themselves. Although two MLWNs did not provide written comments, their comments by phone were supportive of the analysis.

Table 42. MLWNs’ Comments from Review of Analysis and Emergent Insights

<table>
<thead>
<tr>
<th>MLWN Participant</th>
<th>Comments related to their respective Data Analysis and Emergent Insights:</th>
</tr>
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<tbody>
<tr>
<td><strong>Misha:</strong></td>
<td>• On reading the analysis I have a number of feelings – pride, frustration, disloyalty, satisfaction, encouragement. Most importantly I have to say you have “hit the nail on the head” – you fully captured my own perception of my “worth” – I feel recognised. To your credit you have not only identified why and who have caused my frustration but you also allow me the comfort of acknowledgement of my achievements without the necessity to give credit to my superiors for my having achieved them. I feel comfortable knowing that I am recognised.</td>
</tr>
<tr>
<td><strong>Celia:</strong></td>
<td>• You certainly have the knack to pull apart and interpret underlying issues. Your summary is very well written, concise and identifies, clarifies and puts context to “my world” as it was at the time of the interview. To see yourself summed up in such a way is confronting – not in a bad way but in a – yes I am like that – and makes one reflective and mindful. Your insights are accurate.</td>
</tr>
<tr>
<td><strong>Kara:</strong></td>
<td>• It was quite humbling reading through it but also insightful. I am happy with your perceptions and now understand your research better in regards to feminism and politics in nursing.</td>
</tr>
<tr>
<td><strong>Chloe:</strong></td>
<td>• I think the section on knowledge implicit in my self managing strategies is quite accurate, even though I was not actually aware of some of the things mentioned.</td>
</tr>
<tr>
<td><strong>Jasmine:</strong></td>
<td>• On reading Insights from the analysis and the Knowledge Implicit, made me relive a lot of those experiences of that time. I found particularly interesting the disempowering/empowering experiences in the analysis and would agree with your analysis. Unfortunately there has been little change and last year was particularly bad for all of us.</td>
</tr>
<tr>
<td><strong>Poppy:</strong></td>
<td>• I found your analysis interesting and agree with what you have determined.</td>
</tr>
</tbody>
</table>
Summary of Section 1

The two frames of emergent insights relating to Self-Managing Strategies and Implicit Knowledge inherent within these strategies derived from my specifically researcher-developed analytical approach to the ethnographic data. My data analysis approach was informed by Glass and Davis’ (1998) integrated feminist postmodern ethnographic model for nursing research and their trifocal data analysis methods (2004). The lens through which I viewed the data drew particularly from a slight variation of Lather’s (1991b) poststructuralist feminist analytical challenges and Foucault’s (1980) power/knowledge concepts. The analytical approach was applied independently to each MLWN’s data. Participant feedback comments of their respective frames of data analysis reflected confidence in the meanings that emerged. For brevity of the requirements for this thesis I collated the two frames of individual MLWN’s insights which were common to them and incorporated insights which were different. The innovative trifocal analytical lens facilitated a unique appreciation of the socially politically constructed power/knowledge issues inherent in the micro-relationships of the MLWNs in their day-to-day practice as revealed from the ethnographic data.

The eight MLWNs’ ethnographic realist data were viewed from multiple levels of analysis to gain depth and breadth of meaning of their lived experiences. The analytical focus that revealed these two frames of insights, individually and collectively, specifically addressed the four research questions. The process also engaged the participants in partial ways with the research process as a form of fostering feminist consciousness-raising, emancipation and liberating interests. The emergent insights reflected the complex, competing, and dynamic nature of the self-created strategies these women used to accommodate and self-manage being in the cultural context of their working world.

The next three sections in this chapter present realist MLWNs’ exemplars that reflected meaningful feminist postmodern philosophical insights framed within the three always-present and competing discourses and the MLWNs’ respectively analytically identified subjectivity positions. My discussion and critique of the MLWNs’ realist exemplars is further supported by relevant research findings and
In section two, below, is the discussion and presentation of the MLWNs’ insights within the discourse of Values Attributed to Nursing – Between a Rock and a Hard Place.

Section 2. Values Attributed to Nursing Discourse – Between a Rock and a Hard Place

Introduction to this section
This section focuses on the subjugated and marginalised Values Attributed to Nursing Discourse – Between a Rock and a Hard Place. Pertinent realist exemplars will be presented that relate to the MLWNs’ four common emergent empowering and transformative subjectivity positions within this discourse.

Discourse: Values Attributed to Nursing – Between a Rock and a Hard Place
- Subjectivity Positions:
  - Nurse Advocate – Passionate Connection
  - Patient Advocate – Prime Focus
  - Self – Different in the Moment
  - Relationship with Nurse Executive – An Invited Voice

I present this discourse, related subjectivity positions and realist MLWNs’ experiences first. Within this discourse was deeply embedded the MLWNs’ intertwined personal and professional values. It framed their reason for staying in their roles. Valorising the knowledge inherent within the way the MLWNs’ experienced being in this discourse through the related subjectivity positions aimed to highlight, for the MLWNs, it was nurses who were the most appropriate personnel to lead other nurses in the quest for advocacy for patients, nurses, and nursing professional issues.
The discourse of Values Attributed to Nursing – Between a Rock and a Hard Place emerged from reflecting upon the various realist narratives, my observations, field notes and reflective journal comments. It related to values, attitudes and behaviours to which each MLWN made reference. For example, concepts that related to this discourse included: passionate about nursing and best practice patient care, respect for self and others, humble, ethical, assertive, non-hierarchical, empowering toward others, expert nursing knowledge, quality improvement, continuing education, mentoring of less experienced nurses, role modeling, collaborative team work.

Chinn and Wheeler (1985:76), along with other nursing theorists such as Patricia Benner, Jean Watson, Madeleine Leininger (Marriner-Tomley 1994) and Australian nurse scholars (Chiarella 2002; Glass 2000, Glass & Davis 1999; Lawler 1991; Ogle, 2004) identified that nursing’s values which were prided were feminine values. These included: caring, nurturing, healing, and holistic. Nurses’ high ethical standards and honesty were valued by the community above other health and other professional groups (Gallop Organizational Poll 2003). Peter, Lunardi and Macfarlane (2004:frame 3) in their Foucauldian feminist literature review viewed feminist ethics as embracing ‘the values of care, social justice, freedom from exploitation and oppression and the maintenance of relationships and community’.

The kinds of conceptual values revealed by the MLWNs were fundamental to their being a nurse. These values inherently influenced their way of enacting their power within the various and different interpersonal relationships. This discourse was their preferred cultural context. At the same time, it was competing against the dominant background cultural context of two other discourses. The Values Attributed to Nursing Discourse were, thus, reflected in the notion ‘between a rock and a hard place’.

The four subjectivity positions reflected critically important empowering experiences that were meaningful at either a personal and/or nursing professional level. Each MLWN viewed herself as a nurse connected with nurses and patient care. Their priority towards nurses and patients conflicted with the broader
organisational agenda of fiscal constraint. No MLWN altered her nursing values to those from either of the medical science or bureaucratic managerialism discourses. Each MLWN fluidly moved within the different empowering subjectivity positions in the best interests for nurses and patients.

The following presents and critically discusses pertinent MLWNs’ realist experiences that exemplified the four subjectivity positions located within the Discourse of Values Attributed to Nursing.

**Subjectivity Position: Nurse Advocate – Passionate Connection**
The first focus of interest within this subjectivity position related to the high connection the MLWNs had with nursing, as discussed below.

**Personally Connected to Nursing**
In the interests of best practice for patients, the MLWNs pursuits of care, power equity, and respectful reciprocal relationships with nurses were strategies, emancipatory and transformative, that each MLWN applied. These strategies were the basis for professional collegiality and in order to demonstrate valuing themselves. None of the MLWNs’ experiences indicated they had inscribed oppressor traits (Chinn & Wheeler 1985:76). The MLWNs’ experiences indicated similarities to Jones and Cheek’ (2003) comments of the National Review of Nurse Education in Australia 2001 (DEST 2001). They commented that many nurses in that study identified themselves as having a ‘passion for, or great love of, people’ (Jones & Cheek 2003:frame 3). This is exemplified in the following voices of several MLWNs:

**Poppy:** I love my job, love my colleagues, and I love nursing.

**Chloe:** I've always seen my role as one of a caring nature towards the staff. I believe that that's necessary so that they are able to adequately care for the patients, provide the best nursing care. They have to be happy in what they're doing. I just want to do the best I can for the patients and nurses who care for them. Sounds corny I know but it is the truth.
Celia: You can’t take the nurse out of the nurse even though the nurse is a manager, clinical expert or educator or in other roles.

Holly: Of our roles I think it should always be emphasised that you are a nurse and a highly professional nurse. I think we should be seen as a leader and a role model for other nurses and our focus should be to provide excellent patient care.

As a nurse advocate supporting nurses to transition from one position to another was an effective staff retention strategy each MLWN used and which also encompassed a counseling role. Brigit exemplified an empowering manner toward nurses who had been long-term unit team members but needed a break from the high emotional stress of patient care required in this unit. Some nurses became overwhelmed by the intensity required for patient care in this unit and Brigit was sensitive to the nurses’ emotional needs:

Brigit: One nurse couldn’t cope. We’d had some very sad deaths on the ward and she just felt that every time she came to work it was an emotional rollercoaster again. I offered her counseling, I did all the right things. But she said, "Brigit, I’ve just got to move out of this space," and I said, "I totally understand and that’s OK. You can’t come to work and be unhappy and it can’t be a sad memory every time."

Each MLWN demonstrated their commitment to the values of nursing. Throughout my observations no opportunity was missed by the MLWNS to stand alone or collectively speak up for nursing. This strategy had similar characteristics to one of Brennan’s (2005:frame 3) recommendations to reverse the taken-for-granted devalued status of nursing by re-valuing the core caring aspects of nursing as the ‘pinnacle of achievement and status within nursing itself’. Rather than accepting the negative view of other’s about nursing’s value, the MLWNS endeavoured to reinscribe those negative perceptions and experiences into a passion for speaking up and speaking about nursing and nurses’ expertise on every occasion possible. They proactively pursued putting forward nursing and nurses’ value. Inherent in
their self-managing strategies was the MLWNs' resilience within self and optimism (Glass 2007) and critical reflection and reflexivity (Glass 2002-2003). These perspectives could be understood by two personal empowering accounts from Celia and Misha:

**Celia:** After two years of persistence in presenting business cases to hospital executive I've successfully gained a fully funded clinical nurse specialist into this area.

**Misha (email to Helen):**

Since the ethnography I have moved on and achieved a number of personal and career goals and have been given some recognition from my superiors. I will, as usual, push in any direction/arena to support my team/unit and whenever possible the nursing profession at any occasion.

The following focus of discussion related to the MLWNs' empowering management styles. Their experiences related to the empowering subjectivity position of Nurse Advocate.

**Empowering Management Style**

Each MLWN demonstrated and espoused an empowering advocacy philosophy (Vaartio & Leino-Kilpi 2005) in their role. Their principal focus was toward inscribing valuing and caring about nurses and which demonstrated a form of positive governmentality (Holmes & Gastaldo 2002: frame 3). My observations with each MLWN aligned with Goleman’s (1998:318) attributes of emotional intelligence competencies: ‘self-awareness, self-regulation, motivation, empathy, and social skills’. The notions for emotional intelligence had been widely taken up as leadership characteristics for senior staff in many organisations (Goleman 1998). It was also a key feature of personal and professional resilience, hope and optimism emergent from Glass’ (2007) research with nurse academics. Further, the way the MLWNs collaborated with their senior nursing team members fostered, at a localised level, what Reinhardt (2004: frame 7) asserted about a postmodern organisation which ‘will encourage those on the margins to come to the center and
question all assumptions’. Further, that the transformational nurse leader can achieve this especially when there is needed organisational change. Howle (2001) identified a significant correlation between nurses’ perceived empowerment style of their managers and work effectiveness of nurses.

From Brown’s (2002) research projects her theory proposed the establishment of empowering, trusting and emotionally-based relationships among nurses. In empowering relationships Brown (2002), as did Maak and Pless (2006b), also identified the need to feel positive about the organisation, as well as having an inclusive culture. The following exemplifies two MLWNs’ empowering management styles that inhered emotional connections with nurses:

**Chloe:** Nurses have often said I am very fair and even-handed. I don’t favour any one person over another. I try to do my best to make sure they’re happy in what they’re doing. I’m a great believer in ensuring that people get praised. I think we’re all equal, you’re still a person the same as they are. They’ve got expert skills and I don’t think we should boss people around.

**Misha:** I would like people to treat me the way I treat other people. I think it’s important to nurture your staff. When recognition is not coming from higher up then the nurses need someone to say they’ve done a good job. That’s what I do with the nurses. If you want to see people with the same kind of compassion, you’ve got to give it back as well.

**Brigit** and **Poppy** exemplified, as did each MLWN, how their leadership/management style reflected a healthy working culture for nurses as well as their inclusive nature to give credit to others with whom they worked:

**Helen:** My observation of you Brigit, is that you are bubbly, you enjoy your work, you’re enthusiastic and motivating. I see you as a first rate role-model. The nurses must really enjoy working with you?

**Brigit:** You know, it’s not just me, it’s my team. I’ve got a really good supportive staff who do a fabulous job. Nurses come back to this unit.
**Poppy:** I think it’s [healthy workplace culture] because we’ve got young, enthusiastic nurses, and because we’ve got absolutely fabulous staff development nurses . . .

Of another MLWN’s empowering leadership style, I draw from one of my reflective journal notes, as follows:

**Helen (journal re a MLWN)**

She knows every single one of those nurses. She knows their background, capabilities, weaknesses, areas that need to be improved from a staff development point of view. There is clearly no way that anyone but a nurse would be able to undertake the rostering responsibilities - very detailed activity and it’s a juggling act. It needs to be done fast with expertise and with confidence. Managing the roster is not simply paper shuffling – it is all to do with knowing the nurses and communicating with the nurses across the hospital.

As a demonstration of protecting unit nurses from corporate executive level pressure, Jasmine exemplified her empowering management style toward her nurses when confronted by top-down demand to cut staff numbers:

**Jasmine:** I never once said to them, "That's just the executive decision." Instead, I’d say, "Well, this is what we’ll try and do". More often, I’d ask – “What shall we do?” you know, all of us together, or, " How are we going to tackle this?"

**Helen:** So you used a consultative process [with the nurses]?

**Jasmine:** Yes. They need to know that I'm supporting them. But it becomes a compromise to find a way to do what is required.

**Helen:** Was there an acceptance by them of the corporate directive to cut staff because they had the opportunity of talking with you and de-stressing?
Jasmine: Yes. Because - I know what's happened to me when I've not been heard, and I learned from that. I did say to the nurses, I think we've got to stop the stress right here - and you've got to tell me if I'm doing that to you [demanding rather than collaborating]. I'm very aware of it [top-down demands] and I don't want that to go down to the junior staff.” We talked about those issues and that was very important for everybody, for me too.

The MLWNs endeavoured to reward the nurses for their contribution to the team effort of good patient care, but the options for reward were extremely limited within the public health system as the next exemplar shows:

Helen: When the nurses have been working understaffed for two or three weeks – what rewards can you put in place?

Holly: We don't have formal hospital policy regarding rewards for the staff. Basically, the most I can do is to say, "Look, if you want to go after handover the next day, please do so because you've worked so hard.” That's purely an in-house agreement between us. You have to find other ways to say thanks for their hard work.

What was not expressed by the MLWNs as strategies to reward nurses’ efforts and achievements was the frequent positive comments, thanks and smiles of encouragement that each MLWN practised. Such humble and unacknowledged ways the MLWNs behaved toward other nurses was apparent throughout my participant observation periods. The genuineness of these ‘rewards’ was evident in the accepting responses by the nurses and by the readiness for many nurses to do double shifts, or change their roster at short notice when staffing was problematic. One MLWN’s experience showed the support provided by nursing staff as a consequence of her management style, as shown below:

Helen: What I noticed this morning was something I think you take-for-granted – There was a very friendly atmosphere when you were negotiating with two nurses because you were short staffed this evening . . .
**MLWN:** Well, there’s two nurses off sick this afternoon and I needed to ask some of the staff if they would do a double shift. That’s my last resort after first contacting the nurses in our casual pool and if we can’t employ agency nurses. But I don’t panic, I’ve been lucky to always find the staff needed for the shift. I am on quite friendly terms with all the staff, and I know them quite well.

An additional component of the MLWNs’ empowering Nurse Advocate subjectivity position related to mentoring as important empowering practices as discussed below.

**Mentoring as an Inherent Empowering Practice**
Mentoring and creating a supportive culture for nurses formed an important component of the empowering style the MLWNs practiced. In an American quantitative study (n=376 73%) related to nurses’ self-efficacy and structural empowerment, Manojlovich (2005:277) found, among a number of outcomes, that nurse managers who role modelled appropriate behaviour increased nurses’ self-efficacy. Kerfoot (2004:frame 4) asserted that an ‘empowered organization does not have subordinates. There are no bosses. But there are mentors, coaches’. Further, Kerfoot (2004:frame2) noted that the newly emerged empowered nursing professional workforce since the 1990s required a management style whereby the leader leads the leaders. This comment seemed to appropriately fit the MLWNs as leaders of nurses in this ethnography. Glass and Walter (2000:159) found that for student nurses, in their Australian qualitative research, ‘shared caring, learning and reciprocity were major characteristics of peer mentoring’. This kind of empowering style was evident in the following exemple:

**Helen:** In respect to your workplace culture, I think it’s your consistent behaviour, your strong professional values and your empowering approach to staff . . . I'm not sure if you're aware that you are creating that kind of culture and that senior staff recognise it and take it further - it's an unsaid culture. What do you think?
Jasmine: Yes, I hope so, because that's what I talk about with senior staff and how I want them to be. I also try to teach the preceptors how to give feedback; and by role modeling.

Abutting the benefits of an experienced senior nurse mentoring less experienced nurses against Bandura's (1995:20) ideas that school teachers whose talents and self-efficacy was high ‘support development of student’s intrinsic interests and academic self-directedness’. The role of mentor was a particular feature for each MLWN. They were clearly directed toward engaging other nurses, not simply in practical skills, but to be emotionally connected with the values of nursing, especially to be motivated in the care value toward patients. In part of our conversation Jasmine reflected upon her success in mentoring through performance management discussions with one nurse. Jasmine talked about the importance of good two-way communication skills that was based upon empathy and not personal criticism:

Jasmine: With one clinical nurse - we were talking about goals and she said, "Remember you telling me about my listening skills?" because she used to be very abrupt. Apparently, I had said to her, "How you come across sometimes, even I get a bit scared," and she had said, "Do I? No-one has ever told me that before. It really, really affected me and I just made so much of an effort to change". This nurse’s whole approach did change; she took it [my honesty] on board very well. She’s one of my best now. So it’s so important to tell people.

In respect to specific mentoring, Poppy described how important this role was as a significant empowering function for her, as shown below:

Poppy: I’m a preceptor for two nurses and it’s a big job. I really enjoy this aspect of my role. There is camaraderie, not just because I’m their mentor. We support each other; we’re able to make changes in aspects of nursing care that I couldn’t make on my own.
**Helen:** What I noticed is the trusting relationship between you and these nurses. I felt they were enormously proud and eager when they met with you?

**Poppy:** It is exciting. I see them growing in their role because they come less and less often to me now as a resource. I don't solve their problems for them. They now make decisions for themselves.

In the practice of delegating responsibilities to clinical nurses Chloe demonstrated some of her mentoring skills that aimed to be empowering:

**Chloe:** I delegate to the clinical nurses activities like updating standards, policy development, and Quality Improvement audits. They’re happy to do that. Obviously sometimes you have to guide them and sometimes gently sort of say . . . ‘Look, I’m not always going to be around to help, so I need to help you take on leadership roles so that you can sort out problems’.

The following discussion presents exemplar realist MLWNs’ experiences which were located within the empowering subjectivity position of Patient Advocate – Prime Focus. The MLWNs' professional values were ever-present and, thus, integral to their preferred discourse of nursing values.

**Subjectivity Position: Patient Advocate – Prime Focus**

Experiencing an ethical patient care dilemma epitomised patient advocacy as the MLWNs’ prime focus. Of the dilemma for medical professionals in management positions within Australia and New Zealand, Alexander (2000:70) highlighted the role conflict and lack of support when these professionals ‘grappled with ethical dilemmas’. The tension was created when budget constraints negatively affected their clinical ethical obligation related to treatment or intervention decisions. However, non-clinicians ‘did not commonly face such role conflict’ (Alexander 2000:71). Of the ethic of care Gilligan (1997:147 emphasis in original) asserted it was ‘the “goodness” of women, their care for and sensitivity to the needs of others’. This care ethic, similar to the feminist notion of the pursuit of social justice of oppressed people (Cody 2000:192), could be viewed as an inherent ethic in nursing as Holly’s realist exemplar demonstrated. Holly, as with each MLWN, had
a high level of moral maturity and commitment to being a patient advocate. The exemplar shows her success in resisting the power-struggle of financial rationalism with her Nurse Executive. Holly’s exemplar, in my opinion, aligned with Gilligan’s (1997) criticism of the classic psychological development theories of Freud, Piaget and Kohlberg which have not only subjugated but excluded women’s moral development:

**Holly:** The philosophy between corporate management and nursing management is different. The whole focus is different for both careers. As an example, we had an elderly female patient who was being one-one specialised. Purely from a budgetary point of view they [Nursing Executive] wanted to know if I would place her with a confused gentleman; put them together in a two-bed ward. I opposed it and they said, “But, you can’t have two nurses looking after these two patients,” and I said, “Well, the lady’s confused, she can’t make an informed decision as to whether she would like that. She’s elderly. We’ve got to look after her dignity and rights as well.” It was a huge dilemma for the nurses.

This whole thing of money versus ethics requires a lot of negotiation and dialogue to get what is best for patients. It was an ethical issue; we ought not to do that because the lady was confused. You have to be a patient advocate sometimes and say, “No, this is not on.” The nurses didn’t want to do it. It didn’t happen. That’s the sort of thing that nurses are up against all the time. It’s not so much conflict but the difference in thinking. You’ve got people who are counting pennies and people who come from the perspective of patient rights and, where do they intertwine?

There were experiences several MLWNs described that related to how they resisted and/or interrupted existing power arrangements. This was especially in the way they chose which battles to take on (*productive power relations*) when nursing was being overlooked or dismissed. For example, patient related ethical dilemmas in which the MLWNs worked *within* and *parallel* to the Background (Heckman 1999) medical science values culture for the best outcome for the patient. Kara provided an exemplar of the nursing care ethic that on the one-hand showed how
deeply her connection was with advocating for good patient care but the lack of authorial power, as a middle-level nurse, to over-ride unethical medical practices on the other hand:

**Kara:** I've seen some horrid ethical dilemmas. One happened a few years ago where we didn't have much control over it. The man died but went through hell in terms of what the doctor wanted. We presented it afterwards at a nursing meeting where our nursing supervisor said, "Why didn't you come to me? I might have been able to influence the outcome."

Inherent in the subjectivity position as Patient Advocate was nursing practice that fostered patient autonomy. Another of Kara’s exemplars provided a valuable insight into how she approached patient advocacy:

**Kara:** In terms of negotiating with patients, you've got to give them control so they have choices to make. They have a right to be in control of their health care. One of the most important things in nursing for me is to try to imagine myself in that person's shoes, how would I behave and what would I want. That way you're going to have a much better relationship with that person.

An important role in advocating for the best outcome for patients was exemplified in Brigit’s conversation, below, of the success in negotiating for several hours in order to have a patient be cared for by the most appropriate nurses in the most appropriate unit. This exemplar also showed her advocacy role as a taken-for-granted every-day ‘simple’ responsibility. This role which, in reality was not simple, but imbued with competing and complex sociopolitical tensions present in other people’s agendas:

**Brigit:** What’s important for me is to feel that I have achieved my goals for the day. It might be something very simple, like negotiating for two hours with six people to have a complex care patient ending up getting the best care.
Brigit’s focus on the best patient outcomes derived from her way of practicing within her complex role and as self-managing strategy, as another exemplar, below, shows:

**Brigit:** I think the senior nurses all function in their own different way. I’m a hands-on person. I like to be involved with patient care. I like the patients to know who I am so that I can talk with them; know that their family feels happy to talk to me about things. Because, I believe that as a nursing leader it should be like that; not only for staff but also for the patients and their families.

Being key players in a project team that aimed to improve patient care was also experienced as particularly empowering. Two MLWNs’ reflective comments of their achievement of leading hospital projects demonstrate this point, as shown below:

**Holly:** I feel in myself that was a really good achievement... I think it was an innovative thing for the hospital and certainly for patient care. That’s what I’m mainly concerned about. I think it’s everybody’s right, as a patient, to get cared for in better ways.

**Celia:** It’s only when I look back on leading a project that I realise I played a good part in its success and I hadn’t given myself much credit for it before.

Or, in Misha’s case, she periodically sought to take on different short-term work opportunities, to re-invigorate herself as a self-managing strategy, as the exemplar below shows:

**Misha:** I put my hand up to do different things, not because I'm running away from all the responsibility of what I'm trying to achieve. But, because it gives me the opportunity to get my energy back up; to come back with renewed vigor.

The unstructured nature of the MLWN’s day-to-day practice created a dynamic culture within which they related to many and different staff throughout each work day. The following discussion and presentation of MLWNs' realist exemplar
experiences were found to be located in the empowering subjectivity position of Self - Different in the Moment. This subjectivity positions was also integral within their preferred discourse of nursing values.

**Subjectivity Position: Self – Different in the Moment**

In the empowering subjectivity position of Self – Different in the Moment each MLWN acknowledged that their work scope varied considerably on an almost moment-by-moment basis. Issues arose that required them to alter their daily plan. There was no way of keeping to a routine. There was a constant level of controlled hypersensitivity to readjusting the priorities of their work; keeping the myriad of ‘jobs-to-do’ in their head and juggling these to meet deadlines and other people’s expectations. In addition, they needed to be ‘always on the ready’ for the unexpected emergencies. They enjoyed the changing nature of their work and found the fluctuations motivating and exciting. It was empowering for them to achieve positive outcomes especially when the issues related to nursing or patients.

For the MLWNs who held unit management positions, re-negotiating rosters, as an example, was a constant interruption throughout the day: nurses would take sick-leave with or without notifying them; urgent family matters required on-duty nurses to leave work immediately; insufficient establishment numbers meant frequent negotiating with on-call casuals or asking nurses to do double shifts, or asserting the need for agency nurses. Creating and adjusting rosters was a critically important function that required depth of knowledge of the skill capabilities of the staff, the nursing needs of the patient population and potential patient acuity changes throughout the 24-hour period, and many other aspects of clinical specialist nursing knowledge. The complexity of integrating expert nursing knowledge and management/leadership practices meant that the MLWNs were constantly ‘different in the moment’.

Each MLWN’s role incorporated clinical responsibilities and there were different issues that unexpectedly cropped up that made their work interesting and challenging. Street (1992:271 emphasis in original) found in her seminal
ethnography with Australian nurses that they valued problem solving in that, ‘nurses who are trained to respond rapidly and competently to emergencies develop a problem-solving “quick fix” response to both tasks and patient problems’. To be able to draw from their clinical expertise and facilitate resolution of nursing related problems that were raised by other nurses, or at times by medical staff, were critical to feeling empowered for these MLWNs, as exemplified by Celia:

Celia: When there are [clinical] problems that the nurses bring to me to solve, or I’ve identified problems, I try to work with them to find a solution, we try to fix it. I feel as though I’m constantly trying to put out fires, be a fix-it person for all sorts of things to support the staff. I try to make things go smoothly for them and you don’t realise how effective you are at putting out those fires until someone says thanks.

Each MLWN expressed a deep level of importance in relation to their informal relationships with like-level colleagues. It was within their Self - Different in the Moment subjectivity position that they found solace in the open support and freedom to debrief with their colleagues. This was significant to their self-confidence and acknowledgement of their work-related achievements. This kind of collegial reciprocity relationship was important as noted by Persson and Thylefors (1999) from their Swedish study and especially important in Glass’ (2007) study with women nurse academics, internationally. The infrequency for the MLWNs to get together was viewed by them as similar to natural connections with friends. However, it was with their professional colleagues that they felt secure and comfortable to reveal their own vulnerabilities, pose problems arising within their own work setting and knowing their ‘problem’ was not unique but resolvable. Mutually admiring and openly valuing and validating each other formed the cultural context when being with colleagues and where a ‘strong political survival skill necessary to improve the position of nurses and women in contemporary society’ (Glass & Walter 2000:159). In respect to the value the MLWNs found in their selected network of like-minded colleagues, Bandura’s (1995) comment was pertinent. He stated that ‘social support is not a self-forming entity waiting around to buffer harried people against stressors. Rather, people have to go out and find
or create supportive relationships for themselves’ (Bandura 1995:9). It seemed evident that MLWNs were not consciously aware that they may have been applying Street’s idea that:

Collaborative discourse enables nurses to utilize skills of their oral culture to engage in ideology critique and to plan systematic counterhegemonic actions, which empower their patients, their colleagues, and themselves. (1992:276)

Brigit’s story explains:

**Brigit:** I had a quick coffee at half past one today. Half an hour, just to sit and chitchat; its time out with colleagues. We try to do that every couple of weeks. It's not a meeting. They're friends. We discuss things that are also not work related which is really nice, just before you run back to your workplace again. My colleagues are nurses who are the same level as me. We discuss things, like, if it hasn’t been a good day, someone’s given you a bit of a hard time or you’ve had to deal with a difficult situation, it’s very good to download with colleagues. They can relate to what you’re talking about because they’ve had similar circumstances. I think its positive reinforcement to have your colleagues around you.

Being connected with family, having a life external to their work place and being able to disconnect from work issues were critically important for each MLWN. Within the work setting the MLWN’s own personality, as Different in the Moment, influenced the micro-culture of the nursing staff. Below are two exemplars showing these notions and also exemplify self-managing strategies at their personal level:

**Holly:** My family is very important to me. My family values impact upon how I operate in this role. We have a high tolerance for different cultural and religious values and I bring this into our team approach as well, we have a number of nurses from different countries and it’s extremely important that we don’t have any discrimination.
Brigit: When I get home my family help me change ‘hats’ – they need me to be mum, cook, and friend – so that totally helps me stop worrying about work issues.

From my participant observation the MLWNs displayed unique differences in communication styles, leadership behaviour with other nurses, mentoring styles and strategies to gain private time. These unique practices inherently incorporated self-managing strategies. However, the commonality among the MLWNs was their humbleness, as displayed by endeavouring to be non-hierarchical but at the same time fully aware of their senior level of expertise and accompanying responsibilities:

Jasmine: I know the staff appreciate me but I just value them so much. It’s a job I really cherish and I’ve got a great passion for it.

Each MLWN was conscious of the different power relationships in their work environment and they exercised a number of self-managing strategies. One of the self-managing strategies was their ‘stick-to-itiveness’, a personal characteristic that they drew upon to keep motivated. However, they were also aware there was a limit to the sustainability and extent of effectiveness of such a personal attribute, as Celia’s story tells:

Celia: I know people in similar roles to me use different management styles, and have different personalities. Some work to rule - "Sorry, I'm going home now. Good bye." I’ve been in meetings where some just get up and leave because it was knock-off time. If you want any sort of leadership credibility, then there’s that to-ing and fro-ing, you’ve got to be flexible with your time to suit the expectation. For example, staying till the meeting finishes. I also do that with night shift nurses – it’s a way to keep your finger on the pulse and get to know those nurses and their needs.
One of the principal self-managing resistive strategies when in disempowering situations was that the MLWNs withdrew from such situations and moved to empowering situations. This action also showed the MLWNs being different in the moment. Speedy (2004) referred to Collinson’s (1994) proposal that resistive behaviours could take the form of distancing or persistence mechanisms, whereby distancing was shown by avoidance to be involved in organisational processes. In contrast, persistence behaviour was proactive whereby employees ‘demand greater involvement in the organisation’. However, Speedy (2004:159), in relation to organisational practices of control and discipline, referred to the negative impact for employees in that their behaviour was perceived as a form of ‘deviance, aberrant and unjustifiable’.

For some MLWNs, resistance to engaging in corporate activities was an empowering self-managing strategy to distance themselves and, thus, avoid being exposed to disempowering situations. Celia and Poppy discussed experiences that revealed this mixed empowering/disempowering power tension. Both discussed how, at times, they avoided either participating in or attending nursing-related group meetings because they believed, for example that their voice was not being respected. Opportunities to be involved in projects was dependent upon good relationships with Nurse Executives, or there was minimal invitation to contribute to decision-making. Celia and Poppy preferred to engage in their own local level problem-solving issues rather than be subjected to meetings that did not benefit them or nursing staff, generally.

Being a nurse was integral to each MLWN’s personhood. As an example, Chloe showed this in her deeply committed value system of caring about nurses and patients and her frustration that such values were not fundamentally inherent in all who work in the health system:

**Helen:** Why do you keep doing the job?
**Chloe:** Well, because I like the nurses I work with and I like to see the patients are getting good care. I try to focus on that rather than worry about the rest of it. After all we're all here for the patients. But I think there are a lot of people in this hospital that forget that. A lot of people are far removed from patients. It's a bit like that TV program, ‘Yes Minister’. . where they didn’t have any patients in their hospital. I just think, yeah, that's about the size of it for some people, isn't it?

Work-related stress could also be viewed as an aspect of being different in the moment. One MLWN discussed the impact upon her nursing team when she returned from having taken leave because of work-related stress. Her team were worried that they had been responsible for her stress, as shown below:

**MLWN:** We’d had some pretty stressful events and my senior staff asked what they could do to help. I said, "Nothing, that's my job. If I'm not up to doing that job, that's something to do with me, nothing to do with you.” So I was very open about what went on. I mean, there probably has been a lot of reflection by them because they probably never saw me as someone who could get so stressed and they were very distraught. They said to me, "Did we do something wrong? Are we putting too much on you?" and I said, "Definitely not." I mean, that's just pressure I’ve put onto myself. If I wasn't fulfilling my responsibilities to that level, well, I wouldn't be satisfied in myself.

Each MLWN’s self-acknowledgement and pride in her nursing expertise was also integral to her Different in the Moment subjectivity position. In my view the research analysis of the MLWNs' lived experiences showed they were a subordinated group both as women and nurses. However, their frame of personal and professional reference was clearly located in the empowering nursing values discourse and its related subjectivity positions. Their inscribed pride in their nursing expertise, therefore, conflicted with one of Horsfall’s (1996) ideas in which she identified a risk for nurses. She asserted that often ‘subordinated people cannot discern or name their own positive attributes, let alone recognize excellence’ (Horsfall 1996:347). For the MLWNs their self-worth and self-efficacy, in my view, principally
was located within their knowledge of their expertise but which was not readily forthcoming, they gave acknowledgement to themselves with humbling pride, as exemplified by Kara and Celia:

**Kara:**  
I think I’m operating at an expert level and you don’t necessarily appreciate some of those things until someone says, "Did you know?" like yourself, but that sort of thing evolves. I think I’m really well respected and fairly well appreciated, when people talk to me, but I think it’s also a privilege.

**Ceila:**  
I’m at the stage now where I know I’m effective so I don’t have to prove anything, but you don’t actually give yourself credit for the level of effort you put in. I do a lot of mentoring, to give the nurses strategies I’ve learned along the way. I try to look out for the new nurses especially.

Inherent in this subjectivity position was the private emotionality of the MLWNs as this related to their self-acknowledgement of their expertise. The following narrative was from my journal notes that referred to one MLWN’s experiences. The first part was drawn from our audio-taped conversation. The second exemplar derived from my understanding of this MLWN’s comments she provided following the second member check:

**Helen (journal):**

One MLWN, during our critical conversation, unexpectedly broke into tears when I was acknowledging her expertise and excellent relationships that I had observed she had established with her nursing team. As this MLWN explained, her tears were a rare occurrence at work even though there were many occasions when she experienced extreme frustration and hurt. But, on this occasion her tears were a private self-recognition that she was good at her job. The rarity of being congratulated or overtly valued by those with whom she worked meant that she had to find within herself strategies that sustained her optimism and confidence to keep on.
Helen (adjusted from a MLWN’s feedback following the reading of her analysis):

In reflecting upon her experience in the ethnography, this MLWN had undergone a number of personal changes that showed her speaking up for herself of her expertise and commitment to nursing as a self-managing strategy and a re-inscription of nurse’s expertise. During the ethnography she felt she was in a rut and ‘Where do I go now?’ In her ‘self-talk’ she recognised that ‘nothing will change unless you change it yourself and talking to you [Helen] was another bit that needed rethinking; also like when it is in black and white in front of you’ [2nd member check of data analysis]. Since the ethnography, this MLWN has liberated herself: gained the confidence to apply and succeed in acting in different roles that suit her ‘vast skill set that isn’t restricted to nursing!’

What follows is my discussion of another empowering subjectivity position, Relationship with Nurse Executive – An Invited Voice. From analysis this subjectivity position was embedded in the discourse of nursing values. MLWNs’ realist experiences that were identified with empowering relationships with respective Nurse Executives were notable in relationship to acknowledged MLWNs’ clinical expertise. This subjectivity position was not common for all of the MLWNs and highlighted an important departure for the MLWNs whose role incorporated formal management functions.

Subjectivity Position: Relationship with Nurse Executive – An Invited Voice
Within this empowering subjectivity position is discussed MLWNs’ experiences which encompassed two principal areas of attention. The first to be discussed related to their voice being acknowledged and validated by their respective Nurse Executives, as presented below.

Validated Voice
Two participants, particularly, experienced an empowering subjectivity position of Relationship with Nursing Executive – An Invited Voice. These participants’ scope of practice provided a high level of autonomy and independence in their work design. They were acknowledged expert nurses across their respective hospital
and, in particular, with their respective Nursing Executive/s. Their knowledge of nursing practice and its articulation with medical science knowledge was openly legitimated within this subjectivity position. These MLWNs were more frequently than the other MLWNs invited onto nursing profession related hospital committees. They were invited to comment upon hospital/nursing issues, and celebrated because of their expert knowledge contribution to State and national nursing agendas. They were an ‘invited voice’ onto many nursing policy and practice committees.

Laschinger, Almost and Tuer-Hodes’ (2003:418) quantitative study, related to workplace empowerment, found that specialist nurses were ‘more likely to experience positive working conditions, . . . enjoy greater autonomy and control over their work, as well as close relationships with physicians’. Two MLWNs could be viewed to have experienced these kinds of workplace benefits and, further, they were professionally empowered because they were HEARD. The experiences for the other MLWNs in this research did not reveal that their expert knowledge was accorded the same level of legitimation by their Nursing Executives.

It was two MLWNs’ connection with their nursing professional responsibilities and with their selected peers together with the high level of respect accorded them by both medical specialists and Nursing Executives which predominated. Their experiences were seen as empowering and with transformative outcomes. Excluding the corporate financial agenda which negatively influenced all the MLWNs, both of these two MLWNs were supported to achieve their professional goals and received positive and encouraging feedback about their performance.

Kerfoot’s (2004) previously paraphrased statement in the MLWNs’ subjectivity position of Nurse Advocate and discussed in relationship to their mentoring activities, also had relevance to these two MLWNs’ empowering state. In particular this related to their connection with their Nurse Executives, in that the nursing professional workforce since the 1990s had required a management style whereby the leader leads the leaders. The two MLWNs’ experiences demonstrated such a
model. Their Nurse Executives treated them as a ‘peer, colleague and co-worker’ (Kerfoot 2004:frame 4), as one exemplar shows:

MLWN: Sometimes I think some of the things I probably take for granted – my supervisors have been happy with my level of responsibility. I have a lot of freedom to do what’s needed without having being checked all the time but that’s a trust thing as well.

One MLWN emphasised the critical importance of the nursing leadership role her Nurse Executive provided which emerged in a number of conversation topics with me. This MLWN highlighted the risk that the Nurse Executive’s position was to be restructured, by the DoHWA, with a diminution of this position’s legitimate authority within the hospital. The hierarchical leadership position of Nurse Executives located them as holding positional power to advocate and argue for corporate funding to support nursing activities, such as: professional education opportunities; appointment of staff development and/or CNS nurses; nursing research; and fostering the progress of the national nursing agenda for Nurse Practitioner appointments. The potential loss of one/more Nurse Executive position/s at the local public hospital level within WA was viewed by one MLWN as a crisis for the future of nursing:

MLWN: We’re very fortunate because our supervisor is very aware of the impact that our roles make and collectively how we impact upon quality of caring.

We’ve had a huge amount of support for our roles, particularly in terms of the long-term vision with roles like the nurse practitioner role.

High visibility of nursing executives was the second priority for nurse managers in an American study by Knox and Irving (1997) as reported by Ingersoll, Cook, Fogel, Applegate, and Frank (1999). In particular, during times of organisational re-structuring local visibility of the executive staff was perceived by staff as them having concern for them. The visibility of executive nurses also ‘reinforced the staff’s perceptions of involvement in decisionmaking process’ (Ingersoll, Cook,
Fogel, Applegate, & Frank 1999:frame 3). One MLWN’s exemplar aligned with this kind of relationship with her Nurse Executive:

**MLWN:**  
I’ve often invited our Nurse Executive to meet with the nursing team. As an example, s/he recently came for an hour, which was actually a long time, and the nurses asked relevant questions. Probably s/he said some things that we had discussed before but because s/he raised issues there was action taken within the next 24 hours.

In keeping with postmodernism, there was a recognised mobility between different subjectivity positions as shown in the following discussion.

**Shifting Subjectivity Positions**

The fluidity of the MLWNs’ subjectivity positions, their changing lived realities, was exemplified by Jasmine when her relationship with her supervisor changed from disempowerment to an empowering and collegial one when stress levels at the executive level were less. During ethnographic date collection Jasmine had initially expressed deep concern that, at that time, she did not feel her concerns were being heard at more senior levels:

**Jasmine:**  
Our relationship has improved a lot. I feel there’s a different atmosphere now. The pressure from the executive team has settled a lot. It was almost an anti-atmosphere before, where it felt our level of nurses was being criticised for not doing their job. I didn’t take it personally but you can’t help but feel it. Any negativity you do sort of take it on board.

**Helen:**  
Do you feel that at times you’re a mushroom in the dark in terms of what’s actually happening at executive level?

**Jasmine:**  
Not now, no. But, how could that happen? How can people suddenly be deaf?

Another example of shifting subjectivity positions, from a disempowering to empowering position, came from another MLWN’s reply to the review of her respective data analysis. This MLWN informed me that because of excess and
increasing workload she chose to leave the position she had been in during our ethnographic period. Her new position was at a higher level, had a different scope of nursing focus with far less pressure and:

**MLWN:** Strangely I find I get more support in this role and I feel I am listened to more by my nursing superiors! I don’t know why that is!

The fluidity of moving in and out of different subjectivity states also became apparent when I informally talked with an experienced nurse during the ethnography. This nurse affirmed for me that the nursing staff kept a close watch on the non-verbal behaviour of their manager as a gauge to what was happening in the higher levels of the organisation. It reminded me of the intuitive knowledge children have about the emotional state of their parents’ relationship. All the MLWNs were especially conscious of trying not to present their emotional stress to other nurses but as hard as they may have tried to hide their stress, subtle clues could be readily detected as seen in Celia’s comments:

**Celia:** A comment from one nurse – I was chasing up a file and a nurse said to me “Are you having a better day today?” and I said, “What do you mean?” She said, “Well I saw the look on your face yesterday and I could tell that you weren’t having a good day,” I picked up that my non-verbal communication sends out huge messages. I was frustrated yesterday – I couldn’t work the computer! So I recognised that I am watched and the way I conduct myself is an indicator of expectations and are reminders for me.

**Summary of Section 2**

For the women nurses in this ethnography their revealed lived experience showed their commitment and principal connection was toward their nursing professional values and focused on facilitating the provision of best nursing/patient care. It was within this cultural context of their work that revealed experiences that the social construction of being a woman and a nurse was persistently challenged. Their effort was directed to actively resisting being inscribed by the always present dominating patriarchal cultural workplace discourses. Their personal desires and
ethical connection with the Discourse of Values Attributed to Nursing could be understood by the exemplars presented in this section of this chapter.

Each MLWN’s history and identity as a nurse was always present in all that each did within their roles, as taken-for-granted every-day motivations. It was within this discourse that the MLWNs had a conscious sense of empowerment and optimistic possibilities for transformation. Two MLWNs also revealed a sense of emancipation with their positive relationships with their respective Nursing Executives.

This chapter foregrounded discussion and exemplar MLWNs’ experiences of their preferred discourse of practice, Values Attributed to Nursing, within emergent empowering mobile and multiple subjectivity positions. The next section will take a different turn. What follows is the presentation and discussion of the emergent and most dominating discourse of Bureacratic Managerialism. Inter-related with this discourse are two disempowering mobile subjectivity positions as revealed from analysis of the MLWNs’ realist experiences.

Section 3. Bureaucratic Managerialism Discourse - Absence of Care

Introduction to this section

In this section MLWNs’ realist exemplar experiences are presented and discussed as these related to the dominating Bureaucratic Managerialism Discourse – Absence of Care. Two disempowering or oppressive subjectivity positions were located within this discourse.

Discourse: Bureaucratic Managerialism – Absence of Care

- Subjectivity Positions:
  1. Relationship with Nurse Executive – An Uninvited Voice
  2. Government Employee – The Silenced Majority
This discourse was particularly more dominant than the medical science discourse. It principally suppressed the nursing values discourse as an always present discourse during the period of the ethnography. This discourse was also evident in the context of the broader sociopolitical background at government level as discussed in chapter two.

The more dominant and disempowering cultural work context for each MLWN was expressed by many experiences of cost-containment, other fiscal constraints and bureaucratic hierarchical structure that limited the extent of their authority. It negatively impacted upon their ability to achieve their goals, such as, suitable working conditions for nursing staff and the provision of effective patient care. This discourse aligned with Foucault’s (1979) technologies of governmentality. The notion of governmentality referred to the principal administrative decision-makers as ruling the individual as structured conduct. An alternate understanding was posed by Wong Woon Hau (2004:frame 2) in that governmentality functioned ‘by securing [people’s] active consent and subjugation, rather than by direct intervention, domination or oppression’. The hierarchical organisational structure of WA public hospitals, inclusive of levels of authority, accountabilities and responsibilities, reporting structure, policies, procedures, as examples, framed the nature of structured conduct, or governmentality for all employees. The bureaucratic rules were taken-for-granted ways of being, cultural norms, within the organisation.

MLWNs’ experiences that were located in this discourse included: inequity of distribution of funding toward nursing related resources: centralised control at nursing executive level of strategic planning, centralised budget management, lack of nursing workforce planning, inadequate nursing establishment requirements, directives to close beds, directives to increase patient turnover, rejection of appointing staff development nurses and clinical nurse specialists, job-creep, and other issues. Included within this discourse were also a number of experiences relating to ineffective power/knowledge relationships with Nurse Executives, such as: lack of mentoring and performance management, infrequent one-on-one meetings, minimal follow-through of local nursing/patient related requests, openly
hostile comments directed to some MLWNs, lack of invitations for collaborative and innovative problem solving of nursing issues, and minimal presence at unit level. In respect to Nurse Executives’ relationship with many MLWNs, they also used expressions such as: feeling invisible, being marginalised, feeling and being treated like mushrooms, isolated, unseen, insulted, trapped, unknown, and other terms that were understood to refer to disempowerment.

The notions identified above were revealed as disempowering MLWNs’ experiences and were particularly located within one subjectivity position related to the discourse of Bureaucratic Managerialism. This emergent disempowering subjectivity position emerged as Relationship with Nurse Executive – An Uninvited Voice. This was not to say that the medical discourse was not also present in their day-to-day cultural context, rather, it was not as dominating as that of the discourse of bureaucratic managerial. However, it was unexpected to reveal that most of the MLWNs experienced disempowering relationships with their immediate superior, a nurse. In addition, what was also revealed, and important to note, was that no personally disapproving comments were made by any of the MLWNs of their respective senior executive nurses, nor were these nurse executives named. Each MLWN was highly respectful toward their senior nursing leaders.

The second disempowering subjectivity position located within this discourse was Government Employee – The Silenced Majority. This subjectivity position is discussed later in this section.

*Celia* provided a lead-in example to the first disempowering subjectivity position, as discussed below. Her story told of the split tensions between health care workers that focused upon professional values of caring and economic rationalism that dominated the culture in contemporary public hospitals:
Celia: Health itself is now a business. It’s not about being in a caring profession at all. It’s about, “the patient is sick, needs treatment, then we need to get quickly the patient out.” The personalisation to patients has long gone at the bureaucratic political rung – and nurses are in that, whether we like it or not. Medicine used to run the show.

Subjectivity Position: Relationship with Nurse Executives – An Uninvited Voice

The MLWNs’ experiences were extensive within this subjectivity position, Relationship with Nurse Executive – An Uninvited Voice. Thus, a more detailed introduction is provided as a lead-in to the discussion and critique of four integral conceptual components to this subjectivity position.

The predominant disempowering subjectivity position of Relationship with Nurse Executive – An Uninvited Voice was both surprising and not surprising. It was not surprising given the plethora of research related to managerialism that highlighted the top-down organisational pressure to curtail health expenditure. The literature and research (please refer to chapter three) also highlighted the need for executive nurses to be complicit in achieving this specific fiscal corporate agenda Townley (2002) contextualised the move to manage “everything” that permeated this subjectivity position. The disempowering MLWNs’ experiences within this subjectivity position mimicked Townley’s (2002) comment of contemporary management practices. Townley (2002:frame 1) drew from Grey’s (1999) point that, ‘instead of engaging in human relationships, we are now persuaded to manage those relationships . . . instead of caring for ourselves, we manage our health; instead of governing, we manage the economy’.

My discussion of the subjectivity position, Relationship with Nurse Executive – An Uninvited Voice, indicates that some nurses in executive leadership roles, perhaps unintentionally, seem to have ‘internalised’ the values and oppressive practices (Friere 1970:29) more evident in patriarchal dominant discourses. The implications for Nurse Executives whose behaviour and attitudes aligned with patriarchal dominating values was the repression of their subordinate nurses. The impact, as
revealed by this ethnography, was the partial preservation of the status quo of historically subjugating nurses. The MLWNs’ experiences in this subjectivity position were revealed to be mis-matched with the values of their Nurse Executives. Data analysis revealed four aspects of disempowering experiences within this subjectivity position, as discussed in this section.

The public hospitals’ cultural shift from patient focused care to that of fiscal control was experienced as both disempowering and oppressive for the majority of MLWNs. It was anathema for them to put financial value over the service they provided. The care value was integral to each MLWN and in opposition to that of the health system’s culture of predominantly commercial focus. This change in focus within the WA public health system was consistent across the nation (Orrock & Lawler 2006). It also aligned with that which had been reported to have occurred in the United Kingdom (Mannion, Small, & Thompson 2005). The economic rationalist cultural shift especially impacted upon the MLWNs in this ethnography. It was revealed to reduce their ability to fully achieve their nursing goals. Further, their voices were not heard even by their Nursing Executives.

What was revealing from most of the MLWNs’ experiences was the lack of professionalism by some nurses in leadership positions, that was, by some of their respective Nurse Executives. Kerfoot (2004), who was referred to earlier in the chapter, emphasised that in empowered organisations professionalism among nurses was based on collaborative and mentoring relationships,

One conclusion Patrick (2006:frame 8) made from her Canadian quantitative research was that ‘an empowered middle level nurse manager, with strong organizational support and satisfaction in the role is a powerful role model for potential nursing leaders within the organization’. The MLWNs’ exemplar experiences presented in this section reflected their disempowering and fractured reality when there was an unconscious or deliberate distancing by nurses in organisational leadership positions. Where the MLWNs’ experiences showed a lack of organisational support or recognition the MLWNs resisted such negativity and
endeavoured to re-inscribe their self-worth by being locally empowering role models.

Unhealthy and discordant situations, as exemplified in this subjectivity position, were revealed to occur among nurses who were already a disenfranchised and marginalised workforce, by the position they held, being a nurse and by their gender. It was a sad reflection that some nurse leaders had not yet learned how better to enact nursing values with their own professional members. My criticism is not posed without recognition of my own complicity in such disempowering behaviour. I too have experienced my own inability, on occasion, to establish an empowering and collegial culture among nurses and which was deeply distressing to all. I have also experienced marginalisation and subjugation by nurses in leadership positions.

Of relevance to this subjectivity position was an extensive NSW quantitative study (n=803 or 42% response rate) undertaken with public and private hospital nurse managers. This study sought to understand the nature and incidence of various environmental, personal, and work-related factors that related to turnover and retention (Johnstone 2003). Of note was the ranking (44.3%) of combined negative reasons of: dissatisfaction with work environment; not feeling valued by the organisation; insufficient time to satisfy demands of the job; too much accountability without the power to act; and too often having to take work home to finish (Johnstone 2003). Each of these negative factors was present in the conversations with most of the MLWNs. For example, one MLWN expressed her serious thoughts about leaving the nursing profession at the time of the ethnography. Another MLWN did change roles and position to that with a specific clinical practice focus post-ethnography.

The subsuming of different roles and responsibilities into one role for nurses in middle-level positions was noted in the 2001 Report of the West Australian Study of Nursing and Midwifery ‘New Vision, New Direction (Pinch & Della 2001:26). Several MLWNs expressed their criticisms of the limits of career pathways in nursing especially for experienced middle-level nurse managers. The collapsing of
two jobs into one, such as management and clinical specialist, was viewed as an example of hospital executives enacting fiscal constraints at the expense of nursing practice needs.

The subjectivity position, Relationship with Nurse Executive – An Uninvited Voice, comprised four integral conceptual components which are discussed and critiqued below. The first component concerned the value of money as problematic to nursing practice.

The Money Value is Philosophically Problematic
A comment made by Robson (1999:64 emphasis in original) of the United Kingdom’s National Health System’s dilemma, which related to the high attrition of nurses, was that ‘they are treated simply as cost factors by managers who have reduced the service to a state of “anorexia industrialosa: an excessive desire to be leaner and fitter, leading to emaciation and death’. Whilst it was not clear if this comment would have an equitable basis in WA, it could not have been too far from the MLWNs’ reality.

From a report focused upon nurses in the Australian State of Victoria, ‘Work, time, life’ in 1999 Harulow drew reference to the findings that two-fifths of nurses surveyed said that:

High proportions of inexperienced staff caused workload problems, and the overwhelming majority (87%) of nurses working with high proportions of agency staff said the use of agency nurses, who were unfamiliar with the working environment and lacked specialist qualifications, caused concern. (2000:28)

This kind of research finding resonated with the MLWNs’ highly stressful experiences, at the time of data collection, especially as the DoHWA had directed all public hospitals to cease employing agency nurses as a means to rectify the escalating public hospitals’ nursing staffing costs. The underpinning intent by the
DoHWA’s decision sought to encourage nurses back into the public system. However, the local impact was experienced as disempowering. Holly’s comment, below, showed her resistance to passing onto nurses in the clinical setting the negative impact of the cost-cutting agenda, as a directive via her Nurse Executive:

**Holly:**  
*I don’t want my nursing staff thinking everything they do comes with a price. I like to instil the idea that they’re role is directed toward best patient care and the cost really isn’t for them to worry about, except if it is being abused, that’s different. But from a corporate level, its ‘save, save money’, ‘run on less, do more’. I think if we instil that at unit level that is undervaluing nursing – nursing is caring.*

Ferguson and Day (2007) drew attention to the cost efficiency of supporting graduate nurses in their transition period into the workforce. This indicated a possible base for one MLWN’s concern, as noted below:

**MLWN:**  
*My concern was with all the senior nursing staff because we had so many junior staff and I kept saying [to my Nurse Executive], "I can’t accommodate all these junior nurses," The graduate nurses weren’t getting a fair go either. I felt I wasn’t being listened to.*

One of Holly’s examples revealed the shifting tensions in her relationship with her Nurse Executive as well as the tensions between corporate finances and good patient care. Her experience also demonstrated she applied a creep in/up approach, by using sound argument, like that suggested by Heckman (1999), to positively influence the outcome for a patent:

**Holly:**  
*I felt that my supervisor was probably a lot more approachable than usual. We discussed one issue about one-to-one specialising needs that previously I’ve had to fight very hard to get what’s needed and be more assertive and somewhat unpopular. It was pleasant to think that my concern wasn’t discussed from a budgetary point of view, so that was good.*
Corporate fiscal constraints could be understood in several MLWNs’ experiences that related to their arguing for adequate nursing staff as exemplified by Misha’s comment below. One finding from Thorpe and Loo’s (2003:frame 5) multiple studies using grounded theory research with Canadian nurse managers related to ‘unpalatable and inappropriate’ human resource personnel options for nurse managers’ to reduce their establishment numbers in order to accommodate appointing a much needed clinical specialist position on their units:

**Misha:** Business cases have been submitted [to Nurse Executives] proposing to employ a staff development nurse. The request highlighted the risk of staff turnover, the number of nurses being preceptored, the fact that our hospital has increasing numbers of graduate nurses, work experience students - and other health workers who are looked after by nurses. The dollar factor is always the issue more than anything and even when staff leave, their exiting interviews show that having a staff development person would have been so much better as a resource, not that they were complaining about the preceptor but the fact that that person isn’t there continuously.

Kuokkanen and Katajisto (2003:214) in their quantitative Finnish study found that short-term contracts significantly impeded nurses’ empowerment and that they felt insecure and uncommitted to the health organisation. Holly expressed frustration, as an example, of both a lack of her authority as well as lack of support from her Nurse Executive in recognising the need for improved nurses’ contracts to achieve best practice in patient care:

**Holly:** We went through a time, must have been about a year ago, where we were very short staffed. We were employing a lot of casual and agency staff. The hospital executive requested that nurses should all be on 6-hour shifts. We worked out that this would mean most units would be really short staffed. It caused a lot of discussion, a lot of heated arguments in meetings with the Nurse Executives. But, it was always a matter of, “Well, this is the way it is and this is the way you'll do it.” What got lost during that time were staff not being able to attend in-service education, nurses not going to lunch and
nurses doing double shifts. The nurses’ felt so undervalued. Nurses were leaving and there was a lot of unrest.

Also related to nursing shortage, Chloe and Misha identified a common frustration. They perceived that executive nurses had low levels of clout at the top levels in being able to positively influence the assurance for adequate nursing establishment numbers:

Chloe: I may be wrong, but they [Nursing Executive] don’t seem to have the voice that I think they should have. For example, they don’t seem to have the power to argue for the number of nurses that we actually need to run the hospital. They don’t seem to be listened to. Like, they get told, ”No, you can’t have that many. You’re only getting this many,” so in my mind they don’t have much of a say, do they?

Helen: How do you deal with the disappointment of not having your business cases accepted for adequate nursing establishment or funding to support participation in a specialty course?

Misha: Sometimes you just feel, ”Why do I bother?” and that’s probably the worst thing about it. You push and push and push and you just have to keep the energy going otherwise you could say I’d leave. I don’t want to leave feeling I haven’t achieved what I’ve been trying to achieve. I suppose it’s like any situation where you’re trying to achieve something and you’ve been given the responsibility, the position without given the proper authority and if I had a budget and told, ”Make what you can with it,” it would be so much easier because then I’d be accountable, but I’d be hysterical if I stuffed up. But it would also mean I don’t have to keep going cap in hand to get what is needed. They don’t trust us with a budget obviously.

The personal impact for the MLWNs who were responsible for juggling nurses’ rosters with an establishment comprising mostly inexperienced nurses emerged as a constant taken-for-granted crisis. Further, most MLWNs experienced minimal to no support from the hospitals’ nursing executive leaders. The absence of care was
exemplified, for example, in the refusal by hospital executives to appreciate the risks of causing burnout of experienced nurses and compromised patient care when there were too few experienced nurses to orientate/precept new nurses. The ‘problem’ of being forced to accept larger numbers of graduates, refresher nurses and student nurses was fully devolved, without authority to hire the best skill mix, to unit nurse managers like that of some MLWNs. The switching dilemma for the MLWNs was that their genuine professional commitment to support new and inexperienced nurses into their teams was offset by their concern for the lack of immediacy of new nurses to be expert clinicians. In attempting to refuse to accept inexperienced nurses some MLWNs resisted the status-quo of the dominant managerialist model for staffing that took no account of skill level and, at the same time, they were endeavouring to re-inscribe the values of nursing. This is exemplified by the story of Brigit:

**Brigit:**  
Graduate nurses can’t always make the necessary decisions about patient care, for example, how best to manage patients with complex health problems. They don’t have worldly experience [i.e. within the world of nursing practice]. I had to put a halt to taking on graduates because of our big hole in experienced staffing to precept them. To be really honest I couldn’t take on anyone else and be fair and equitable and give the graduates the best that we can.

In the following conceptual component of this disempowerig subjectivity position the MLWNs’ experiences revealed extremely unhealthy and inappropriate bullying behaviour by some Nurse Executives toward MLWNs and other nurses.

**Bullying and Humiliation by Nurse Executive**
A plethora of research existed about bullying in the workplace of nurses (David 2000:89; Clare & Hofmeyer 2004; Farrell 2001; Glass 2007, 2003a, b, c, 2001a, b, 1998, 1997; Jackson, Clare & Mannix 2002; Street 1992) and which was detailed in chapter three. Speedy (2004) referred to McCarthy’s (1996:48) NSW Report about bullying in organisations that applied a Foucauldian critical approach. Speedy noted that this report suggested that ‘there are currents of violence within
organisations that are readily channeled into tyrannical behaviour because of “a brutal struggle for efficiency and profit in turbulent market conditions” (Speedy 2004:153 emphasis in original). Workplace bullying was defined by the Human Rights and Equal Opportunity Commission (2004:frame 1) as ‘the repeated less favourable treatment of a person by another or others in the workplace, which may be considered unreasonable and inappropriate workplace practice’.

Some MLWNs identified reluctance to individually exercise their political power and instead pursued collaborative action with like-minded colleagues to propose change with the Nursing Executives. Their action could have aligned with a comment made by Clare and Hofmeyer (2004). Clare and Hofmeyer (2004:350) commented that ‘since nursing has historical links to the military and religious orders, nurses have traditionally been influenced by societal sanctions against women who openly assert their power’. Clare and Hofmeyer (2004:350) referred to several nursing research projects that applied critical social science methodology (e.g., Clare 1993, Varcoe & Rodney 2002) that exposed some of the ‘coercive misuses of power in the nursing workplace and society through making visible oppressive social structures and conditions’.

The following are parts of conversations with two MLWNs that related to disempowering experiences that exemplified bullying and humiliation:

**Holly:** A comment was made when one senior nurse was very vocal and was told by the meeting convener [Nurse Executive], "You must remember now that you've got a white collar on and you can take the union blue collar off." I mean, that’s bullying if you ask me and, hey, everybody's got the right to belong to a union if they want to.

*I think that sort of thing is aimed to disempower them. People who stand up for their rights and continually fight for them are known as stirrers in these environments, and they are. The thing is they [Nurse Executives] back down to you after a while because they know if you can back it up with facts, they can't argue otherwise. Or they can, but they make themselves look silly.*
Poppy: Part of my rebellion was to withdraw from all committees when I was having a problem with the Nurse Executive. Then I was invited back but I had reservations about speaking up because I always felt that I couldn't bring things to meetings any more. That slowly resolved, perhaps because I discussed it with my colleagues and they would take the issues to the meetings.

There have been meetings when we’re actually put down - we’re actually denigrated in front of other colleagues in that, "Here she goes again," sort of - they're non-verbal behaviours, they don't say it. But at one meeting we were told a new senior nurse had been appointed and they said of this person s/he is, "Not like all the other’s here!" Now, there were other people [non-nurses] at this meeting, and they were offended by that.

The subtlety of bullying and the intent to humiliate could be clearly seen in Misha’s experience of being in meetings with other senior nurses, chaired by a Nurse Executive:

Misha: "Well, what shall we talk about today? or Should we bring something up that's pretty contentious? Oops," and if we do, [slaps hand] smack? The fact that you’d see other colleagues suggest something and get more or less shot in the foot, you know, either visually or, "No, it wasn't a good idea to suggest that we talk about this." It was sort of like this awful fear factor and I thought, "What is this about? I thought this was an opportunity to share information and talk to one another!"

It's just that that kind of behaviour sends a message to those people who are in acting positions, for instance, who then don't bother to come to meetings or think, "I'm not going to say a damn thing. I'm going to sit here and just look."

Also within this disempowering subjectivity position were numerous experiences where the MLWNs felt isolated and was viewed as relating to notions of bullying, as discussed below.
The Noise of Being Isolated, Bullied and Humiliated by Nurse Executive

Where bullying was outright unacceptable behaviour and was personally extremely disempowering for those MLWNs who disclosed it, the experience of being isolated within the work setting impacted more subtly but potentially equally as negatively. Feeling isolated was revealed to create a decline in organisational commitment, lowered morale because of the lack of feeling valued, and confusion about the reason for the isolation. The following discussion in this component of the subjectivity position of Relationship with Nurse Executive – An Uninvited Voice related to a number of MLWNs’ disempowering experiences that exemplified being isolated and the unacknowledged ‘unsaid’s and ‘noise’ of disappointment, frustration, confusion, and other negative feelings.

**Poppy:** There is a lot of frustration in the role. There's a lot of suppression of the role and I don't know how you can change it. I just feel sometimes that we need to be respected; it needs to come from a high level, from executive level.

**Chloe:** Often, I feel like the people in executive roles are more inclined to listen to an engineer or the head of supply rather than us.

Speedy and Jackson (2004:57) in an extensive literature review that related to power, politics and gender within nursing noted that the literature (e.g., Graybill-D'ercole 1998; Robinson-Walker 1999) ‘suggests that a lack of role-modeling and mentoring for potential female nurse leaders may contribute to the under-representation of women in leadership positions’. Thorpe and Loo (2003), from their grounded theory research with Canadian nurse managers, also highlighted the need for greater support for middle level nurses by their senior staff. A small American survey (Gresham and Brown 1997:frame 4) found that middle level nurse managers’ preferred their nurse executives to use Hersey and Blanchards’ (1988) situational leadership relationship styles of ‘selling and participating’. From the perspective of nurse executives, Parsons, Fosbinder, Murray and Dwore’s (1998) survey found with nurse executives that having a role model or mentor was the most important factor cited as a key preparatory feature for their job. My response
to these international research findings was that MLWNs, each with many years experience in senior positions, revealed limited or no role-modeling or mentoring from their Nurse Executive which exemplified the basis for their experiences of isolation.

_Holly’s_ experience of meeting once per fortnight with her Nurse Executive, similar to most other MLWNs, did not incorporate the notion of mentoring as part of those meetings. Instead, it indicated a lack of receptiveness by the Nurse Executive to actively listen to her ideas or mentor her. As there was no proactive mentoring by her senior nurse, _Holly_ sought mentoring from a privately identified mentor. Further, _Holly’s_ comments indicated her political awareness that ‘nurses and women obviously have more power together than separately’ (Glass & Walter 2000:159).

**Helen:** _How would you feel about suggesting that your supervisor meet in your office?_

**Holly:** _It probably would be better if our supervisor came to visit us in our environment. But I wouldn’t suggest it. I’d discuss it with my colleagues and if they were in agreement, then we’d raise it in the meeting. I think if you raise it as a group, and if there’s general consensus, you’ve got a better chance of being successful. It’s having strength in numbers [in proposing a change to the Nurse Executive]. Also, if they [Nurse Executive] see that it’s a useful strategy and it’s not just one person, then obviously it makes that person think, "Well, there’s value in this," not, "Who in the heck does she think she is? How dare she suggest I should go to her office?"

Of the doctor-managers in Forbes and Hallier’s (2006:frame 6) research, one doctor voiced her/his frustration at being isolated when the doctor challenged suggestions/decisions made by senior managers, in that: ‘Some managers regarded us as getting in the way and to be sidelined at every opportunity’. Wesorick’s (2000:frame 2) comment resonated with the depth of emotion associated with disempowering experiences of being isolated, ‘there is an air of dehumanisation, fragmentation, and focus on doing more, faster, and better.
Intelligent, caring, and committed people feel alone, powerless, and voiceless in the midst of the demands. There is an exhaustion of the soul, the harbour for our deepest values. The following two MLWNs’ exemplars and one of my reflective journal comments showed how isolation could occur as a consequence of distancing and tension if there was poor connection between senior hierarchical levels,

**Poppy:** Nurses are not allowed to stand up to their seniors, not allowed to be honest. You have to be seen to go with the flow, you have to fit the mould. It’s very difficult not to fit the mould in senior nursing positions. I don’t fit the mould.

One senior nurse didn’t agree with a Nurse Executive’s decision and she complained to her. As a result she felt victimised because she was prepared to stand up for the right thing. But it seems that in nursing if you do stand up, that’s not always seen as acceptable. We often feel powerless.

**Helen:** That sounds like a double standard, where on one hand there’s an expectation that you will take the initiative to bring about change and raise issues with your supervisor but when you do, that’s frowned upon?

**Poppy:** We’re actually powerless. We’re in the middle and, as I say, I have an exceptional nursing executive, okay, and she supports us very well, but we’re powerless. We’re not actually appreciated. I don’t know that people understand our roles very well. I don’t think they understand how essential we are to the organisation.

**Misha:** Sometimes I feel even when you want to say the things [at meetings chaired by Nurse Executives], you feel that you can’t. You feel that you’re not allowed to be honest, so to speak. There’s a culture of fear - by admitting to something you’ve done wrong or a problem you can’t figure out, it looks like defeat and a failure whereas in fact you shouldn’t have to feel like that. It’s a bit like the surgeon that slips up and doesn’t tell anybody else about it. It could have helped the next person to prevent them from doing something. It’s all a learning curve.
**Helen (reflective journal):**

*Most of the MLWNs’ offices are located in out of the way places – doesn’t give much prestige to the positions they hold. They have to walk the corridors to remain visible to their staff. There are lots of closed doors down the corridor.*

Many MLWNs identified feeling isolated because of their exclusion in any level of strategic planning. These similar kinds of feelings of isolation featured in a grounded theory research with directors of nursing (n=25) in the Republic of Ireland (Carney 2003). Carney found the following:

> When involvement in strategy development took place, enhanced downward communication flow occurred serving to produce a cascading effect downward to middle managers, resulting in greater management cohesion and effective communication. Conversely, exclusion in strategic decision-making resulted in poor communication flow and a lack of access to senior managers, resulting in a sense of isolation, of being controlled and of decisions being made that were of major concern to nursing and the organization without any involvement with the Director of Nursing. (2003:frame 2)

**Chloe**’s comment reflects similar notions as posed by Carney (2003) if middle-level nurses are excluded from strategic direction planning:

**Chloe:** *I don’t believe enough is communicated to us about what is the vision. I think they hurriedly put together some statements of that kind because they needed to meet some deadline. But I don’t feel there’s enough input from nurses at our level- it's just - I mean, I wasn’t asked to have any input into it!*

In **Poppy**’s exemplar below, she showed a double edged frustration – on one hand she was supportive of the changes being introduced by the Nursing Executive team. However, she felt isolated because senior nurses’ expertise was not sought,
therefore not valued as important contributions to the future success and direction for nursing in the hospital:

**Poppy:** There's no strategic plan in nursing and if there is, we don't know it. The disappointing thing is we went to a hospital-wide sharing information meeting [about a strategic plan]. There was stuff that had never been discussed with senior nurses. Even though we have an executive nursing team they don’t include us in decision-making or strategic planning. Yet, they have some really good ideas and they've implemented a lot of change that I respect despite the history . . . We are mushrooms. I mean, we're kept in the dark and we're fed bullshit. That is absolutely true, and we all feel that way. I think that gives us a feeling of camaraderie because we all feel that we're imposed on.

Isolation can take many forms but with similar outcomes of frustration and resistance. For example, when one MLWN rejected being forced to be involved in a decision that would impact upon a senior nurse position in her unit, her Nurse Executive waited until she was on leave to implement the change anyway:

**MLWN:** As a professional courtesy, I said, "I feel that I'm being put in a position where I'm being forced to make a decision that I have no right to make on behalf of other nurses.," . . . and I was told, "That's your opinion and where you're at. It's certainly not my belief." The outcome was that when I was on leave the change was made. With that, though, there were no meetings convened with other nurses. I had specifically asked to have meetings so that the nurses’ viewpoints could be heard. There was no looking at what the implications would be. So, when you are asked for your opinion, you think, "Why bother asking us if you're not going to listen to our issues and concerns?"

But nurses don’t speak up. Many are frightened of [her/him] in that regard. I've not ever been frightened of [her/him] if it's an issue that I feel strongly about, I will speak out, but otherwise I stay very much in the background. I pick my wars.
Two MLWNs made reference to their disappointment of not being acknowledged for the senior nurses’ contribution toward the hospital’s quality accreditation success:

**Holly:** *It's always irritating when you fight for something and you win and somebody else takes the credit. But if at the end of the day patient care is enhanced, then I guess, so be it. I mean, your name's only in lights for a little time anyway and then it's soon forgotten, so. We rarely get praised. Although, to be fair, we got a letter saying how well we'd worked in hard times.*

**Chloe:** *The accreditation process is a very good example. I think that the senior nurses do the greater majority of the work at unit level in preparing for accreditation. But I don't think we get very much credit for it. I think the credit goes to those at the top who communicate with the auditors. They stand there, showing off their hospital and how beautifully it runs but I don’t feel that we get much acknowledgment.*

In the next component of this subjectivity position several MLWNs experienced not being taken seriously by their Nurse Executives. This exemplified a commonality of disempowerment.

**No Wonder Middle-Level Nurses Aren’t Taken Seriously!!**
Continuing the discussion within the subjectivity position of Relationship with Nurse Executive – An Uninvited Voice a number of MLWNs further revealed experiences of not being valued as senior organisational members. These experiences were closely linked with feelings of not being taken seriously and which emerged from data analysis as being disempowering.

The following discussion and exemplar MLWNs’ experiences highlighted the incongruence for the variously different surveillance mechanisms within which they were required to comply. As registered nurses they were under their own and other nursing professionals’ surveillance to comply with stringent professional codes of
practice, conduct, ethics, competency standards and decision-making frameworks (Australian Nursing and Midwifery Council 2005, 2007). They had each been merit selected for positions which incorporated expectations of being clinical experts. However, as hierarchically positioned middle-level nurses they experienced subjugation and felt unimportant in the hospital’s organisational business. This was exemplified by one MLWN’s comment about her position within the hospital:

**MLWN:** I feel that if you said you were a manager of a Coles Myer store, people would say – ‘Oh, wow!’ but I don’t get that kind of recognition for the position I hold. It’s not the money, it’s the principle of not being recognised for the considerable responsibilities we have.

What became apparent during the ethnography, and principally recorded in my reflective journal, with respect to the MLWNs who held Nurse Manager or Clinical Nurse Manager positions was the low level of significance and value extended to these women by staff more senior to them in most areas of the hospitals. There were numerous references these MLWNs made that framed disempowering and oppressive experiences that related to the subjectivity position of an Uninvited Voice by Nurse Executives. Common notions emergent from the realist data analysis located exemplar experiences of the following: they were overtly devalued (e.g., not invited to participate in nursing or hospital strategic planning; not trusted to manage budgets but expected to create annual nursing workforce budgets; expected to complete low-level clerical work (no secretarial support was available); no authority to manage nursing establishment – no authority to hire agency nurses; surveillance over nurse’s registration status; not being able to requisition to replace outdated computers); undermined (e.g., not supported to ensure specialty units were staffed with correct skill mix of nurses; no budget allocation for staff nurse development or clinical nurse specialist positions; no acknowledgement for the need to fund nurses to participate in specialty nursing courses); taken-for-granted (e.g., no credit accorded or resource allocation but expected to be the principal change agent and prepare staff and documentation to achieve organisational compliance of quality audit assessment; directed to meet patient care requirements without adequate nursing establishment or skill mix of nurses; directed by
executive staff to take on additional work as new projects emerged; be a ‘pillow chaser’; be a bed chaser); silenced (e.g., ethical patient care dilemmas challenged by Nurse Executives; credit for achievements taken by more senior staff; nurse/patient safety requests not heeded; restricted information flow from Nurse Executives); invisible (e.g., passage of weeks without one-on-one meetings with Nurse Executives; no mentoring/ career performance development meetings; not invited onto committees or project teams; no presence by Nurse Executive at unit level; cubby-hole offices located out-of-sight); and bullied (e.g., criticised in the presence of other nurses – white collar vs blue collar union criticism). These kinds of experiences were among many understood as disempowering or oppressive; their nursing values were subjugated. There was an absence of care as revealed by the lack of acknowledgement or valuing of MLNWs’ many important contributions toward the success of their hospitals’ foundational business activity of nursing service to patients.

One MLWN who held a managerial role showed one of her empowering self-managing strategies. She pushed the boundaries and resisted being disempowered when there was a lack of recognition toward her and no credit was given to her contributions to the hospital’s accreditation success:

**MLWN:** There was a function to celebrate the hospital’s accreditation. I didn’t get invited. So, I just invited myself. I introduced myself to the auditor and s/he just sort of looked at me like I had two heads but I thought, “Too bad. I did a lot of work to help the hospital achieve that award. I felt that I deserved to be part of the celebration.”

The MLWNs who held formal management roles were concerned about maintaining their clinical expertise because administrative responsibilities took precedence. Each of the eight MLWN’s interest to retain clinical expertise was, however, fundamental to their being nurses. O’Rourke (2001) emphasised the significance of excellence in clinical practice as a means of legitimising nursing leadership. Celia’s comment of herself gave credence to O’Rourke’s (2001) claim of the risk of not feeling legitimated without clinical expertise:
Celia:  *The recognition for yourself only comes if you prove your kudos, do what you do clinically rather than any other way.*

Another MLWN’s comment indicated her concern of not being able to effectively support the nurses in the practice setting because of her managerial responsibilities:

MLWN:  *I’d like to spend more time in the unit with the nursing staff. Sometimes I don’t feel I have enough time to guide them and help them if they’ve got any problems.*

The lack of clerical support was consistently noted as a frustration among the MLWNs. Either these nurses were highly paid clerks or the nature of their work was poorly understood by Nurse Executives. The matter of discrepancy between what the MLWNs actually did against what other nurses perceived they did, inclusive of senior and junior nurses, was not a small matter, it seemed to be a critically disempowering experience. The MLWNs did not have clerical support which meant the scope of their responsibilities incorporated all of the clerical activities. Neuberger (2005:frame 1) brought attention to the concern that excessive bureaucratic paper work was de-skilling nurses and ‘making a nonsense of their nursing and caring role’. The excess paper work was creating an emergent risk aversion culture within British public services. This was exemplified by one MLWN’s comments about nurse manager’s roles within her public hospitals:

MLWN:  *The workload for Clinical Nurse Managers/Nurse Managers is becoming so huge that I am fearful that they will not find nurses for these positions. Nurses who want to advance in their career tend to put up with the role as it is often the only stepping stone to higher position. . . . A lot of the paperwork belongs to a clerk. It’s not a nursing job.*

One MLWN showed me her annual budget which she developed but did not control throughout the year. There was minimal opportunity for her to monitor budget to actual expenditure. This was an example of the Nurse Executive having delegated
accountability but without any level of authority. It was not devolved management but exemplified centralised management whereby the executive nurses controlled the micro managerial activities at unit level. The incongruence of budget management was exemplified in one of my journal references:

**Helen:** I was present at a senior hospital staff meeting today. The finance executive spoke about the financial status of the hospital, not necessarily in great detail but indicating a need for closer monitoring of the financial status. I found that odd, because the nurses in middle-level positions have very little input, control or authority of budgets. So there was a discrepancy between their directive to cut their resources and do more with less, without necessarily the authority at the local level to control their budgets.

As an Uninvited Voice subjectivity position **Celia** viewed the job creep in her role like that of being a ‘packhorse’. Not dissimilar to one finding from Forbes and Hallier’s (2006) research. They identified that doctor managers felt under strain because hospital managers were ‘piling on the pressure despite our doctors retaining heavy clinical workloads’ (Forbes & Hallier 2006:frame 6). Adding to the pressure of being unable to resist Nurse Executive requests to take on more work, there was an expectation by unit nurses for the MLWNs to be more visible. This double-bind experience was also identified by Thorpe and Loo (2003) with Canadian middle level nurses. Those nurses were also required to take on more work. Further, they found that nurses at the clinical level felt valued when their managers were visible (Thorpe & Loo 2003). This catch 22 situation in which there were multiple levels of ‘visibility’ expectations for the MLWNs could be understood as inherently disempowering because they could not be everywhere for everyone at the same time. This could be understood from the following three comments:

**Chloe:** The straw that just about broke my back was further increases in my workload. This extra work was being dished out to us at meetings, without first discussing it on a one-on-one. I was disappointed that my boss who was present at the meeting made no effort to stand up for us. Many of us are reluctant to say anything at the meetings as we often are made to look like
fools or simply told that it is part of your job.

**Brigit:** Now, there's some people who may spend a large portion of their time sitting in their office doing stuff. I hate doing paperwork but I do it because that's part of my role. It might be that if I didn't do it here, I'd have to take it home which is probably easier for me; do it in the quiet where my pager is not going off. But I much prefer to be out and available for the nurses.

**Helen:** I'm impressed with this MLWN’s vivaciousness and enthusiasm and constant level of high motivation. She is on edge all of the time, she's watching and listening and responding immediately to any demand by staff. She is encouraging and supporting the nurses that come to her. I don’t think the nurses know how much work she does behind the scenes – but she is not reading the newspaper!

The notion of being a ‘packhorse’ also related to span of control. The impact of span of control for nurse managers in the American Midwest health system was quantitatively studied to understand the impact of employee engagement (Cathcart, Jeska, Karnas, Miller, Pechacek & Rheault 2004). Over a 25 year period the study applied a validated tool developed by the Gallop Organization. They found a strong correlation between the manager and employee relationship. Unsurprisingly, these researchers found that employee engagement decreased as work scope increased (Cathcart, Jeska, Karnas, Miller, Pechacek & Rheault 2004). One pertinent finding was that employees within work groups of less than 15 employees ‘felt their opinions counted in the workplace’ (Cathcart, Jeska, Karnas, Miller, Pechacek & Rheault 2004:397). Another study outcome was that there was a significant increase in the number of nurse managers and with a more appropriate span of control. As an example, up to a 50% reduction in employee span of control for those managers who had previously been responsible for more than 80 employees (Cathcart, Jeska, Karnas, Miller, Pechacek & Rheault 2004). For some of the MLWNs in the ethnography, their span of control was certainly up to or greater than 60 nurse employees! Concerns of excessive span of control
raised by some MLWNs with their resesptive Nurse Executive was not acknowledged as important.

The notion of not being taken seriously was also inherent in the experiences where, for many MLWNs, there was an absence of mentoring. This was revealed as an absence of caring about the professional and personal work-related needs of the MLWNs, senior professional women and exemplified by Celia’s comment:

*Celia:* There's been no guidance in how to do my job and then hence there’s no feedback in lots of ways . . . But I have been in roles where the person above me mentored me.

The lack of orientation and subsequent mentoring of many MLWNs’ progress in their role was a common conversation topic. This surprised me as preceptorship (structured mentorship) programs had been important orientation processes at the local nursing practice site for more than twenty years within the WA public hospital system. My surprise was that no similar educational orientation programs were evident for middle-level and executive management nursing positions at the time of the ethnography. Perhaps the lack of executive level nurse preceptorship programs negatively impacted their confidence and skill to effectively mentor their middle level managers, unless they had had previous mentoring or coaching experience themselves.

Celebrating success and collegiality with food was a common social practice. However, when the success was an outstanding organisational big event, the giving of ‘a cake’ was viewed as demeaning and insulting, in the least, and with consequent feelings of disempowerment for the MLWNs. Brown (2002:frame 5) from her phenomenological study had one nurse share a not-dissimilar experience to that of one MLWN in respect to reward from her Nurse Executive: she was given a ‘lollipop’ as part of a “Nurses’ Week” celebration. Many MLWNs in the ethnography expressed disgust at being given ‘a cake’ as thanks when the hospital achieved accreditation. Brown (2002:frame 5) emphasised that the reward nurses
really sought was ‘empowerment that is based on recognition and support of their full worth as human beings’, as exemplified by Poppy:

**Poppy:** They [Nursing Executive] give us a party at Christmas and I’m afraid last year I didn’t go; I felt hypocritical because of the history. Food is not a reward for me. My reward is for them to be honest, open, and communicate with me.

To a lesser extent the subjectivity position of Government Employee – One of the Silenced majority, as discussed below, formed a small but important component of the MLWNs’ realist experiences revealed as disempowering. This subjectivity position provided insight of the dislocation experienced by local level health care practitioners and the politics at higher governmental levels.

**Subjectivity Position: Government Employee – One of the Silenced Majority**

Within the Government Employee – The Silenced Majority subjectivity position several MLWNs found it very frustrating and disempowering that practicing nurses had limited voice, individually or collectively, in the development of government health policy and planning. In particular, Kara was passionately frustrated that nurses, at the coalface, had no input into discussions about organisational restructuring that impacted upon nursing positions of public hospitals. During the ethnography the DoHWA implemented more than one restructuring of the Perth metropolitan public health service structure. These changes were perceived by several MLWNs that the influence of the nursing profession was being diminished at its leadership level within the hospitals. There was a re-centralising of some aspects of public hospital management as a strategy to improve financial accountability (please refer to chapter 2).

In the Minister for Health’s media statement (21 September 2005:frame 2), in relation to his ‘WA Health Clinical Services Framework’, he noted that this framework was ‘developed after extensive consultation with medical staff and the community’ – but it was not inclusive of nurses! It would be interesting to know whether the consultation took into consideration issues that were raised by Flegg
(2005) in his exposé of the major problems confronting Queensland’s public hospitals. A Liberal Party member in the Australian State of Queensland, Flegg (2005:frame 1), noted that ‘a culture of bureaucracy was compromising patient care in Queensland’s public hospitals with new figures showing 75 per cent of all new hospital staff were employed in administration’ and that the nursing workforce had dropped from 41.9% to 39%.

In late 2005 the public hospitals in Perth were in crisis, in fact two tertiary hospitals were on emergency disaster code alerts because of insufficient resources to meet the admission rate requirements for sick people (Rule & Penn 2005 October 25:1). The cascading stress upon workers, especially nurses, during these kinds of perennial crises was an example of a disempowering factor that health professionals have no voice to change. The expectation upon nurses, for example, was to push patients through the system in haste. Although there was a concerted effort by the DoHWA to attract an additional 450 graduate nurses into the public hospital system in 2006, the Australian Nursing Union (WA Branch) was criticised by both the State government and the opposition for its call for an urgent nursing summit to address issues of work stress associated with the hospital bed crisis (Rule 2005 October 28:17).

Although there were few MLWNs’ experiences that emerged within this subjectivity position, it was important to reveal the feelings of anguish associated with the disempowerment of being a non-voiced government employee but an integral member of a patriarchal system.

As an example, one MLWN brought to my attention the persistence of the negative impact at the local nurse/patient level by the DoHWA’s cost-cutting demand for a more rapid patient turnaround. This pressure to comply with the government’s agenda, via the public hospital hierarchy and onto middle-level nurses, as an example, resulted in four middle-level nurses in her hospital leaving their jobs to take up less stressful positions, and another leaving nursing altogether!
When an unexpected restructuring at executive hospital level occurred during the ethnography another MLWN experienced a high level of anxiety as to the negative impact this would have upon nursing and nursing leadership. The intent of the change, from this MLWN’s understanding, was made known to hospital staff by email from the DoHWA. The changes meant there would be one Director of Nursing (DON) overseeing responsibility for nursing across a number of metropolitan public hospitals and community health services with the demotion of the local hospital DON authority. Similar changes were anticipated for the medical directorships. From this MLWN’s account there had been no consultation with the executive staff affected by the restructure and which demonstrated, in her opinion, that nursing was not important or valued within the higher echelons of the government health care system. The exemplar, anxiously discussed by this MLWN, identified the lack of influence public sector employees, such as nurses, have at government level and the flow-on negative impact upon professional workers. Speedy and Jackson (2004:56) referred to significant organisational decisions related to nursing as commonly ‘imposed’ upon them with minimal regard for the wider ramifications upon nurses and nursing. Borbasi, Jones and Gaston (2004:168) highlighted the difficulty for nurses to influence health policy development and referred to literature that noted this could be ‘attributed to a weakness in nursing leadership at all levels’. Kagan (2006:317) referred to Ashley’s message from her feminist nursing research in 1976 when she urged for the need ‘that nurses retain control and power over their professional practice and providence’. The following conversation exemplified the way the MLWN viewed this major and sudden disempowering change:

**MLWN:** Essentially the whole of our top layer organisational structure will go. So we will have no local director of nursing, no local director of medical services or all the other key director positions that help with running the hospital – a DON in an office somewhere who really has none of the day-to-day running [responsibilities], just functional responsibility for certain things. It’s a real dilution of the nursing role. So I can only see that that will impact on nursing leadership and patient outcomes. It will affect standards, the effect of trying to achieve good patient care - there won’t be
any local leadership and influence for nurses in particular - a role to retain rather than to lose. Nurses lose their voice.

In a different perspective about health workers having no voice in government funding health related issues, arose in my conversation with Jasmine. She referred to the inadequacy of physical space to meet current patient needs and that of the unit’s health worker teams because the buildings were very old. She referred to the flexibility of health workers to make the most of their physical environment. But, more importantly, was the ‘homely culture’ staff created despite the physical environment. From my observations of Jasmine it was her caring and collaborative management style that set the tone for a healthy workplace:

Jasmine: There’s always a difference between federal and State government. We need more beds in public hospitals. I don’t know if our health funds are being wasted but, - I mean, they’ve tried - with the nursing dollar they’ve tried to cut it down. Even though it’s an old building, it’s like a really comfortable home. It’s also how the staff members feel about it.

As a final exemplar of this subjectivity position was a common example where the MLWNs’ experiences could have been either located in this subjectivity position or in the ‘Uninvited Voice’. Most of the MLWNs experienced a lack of inclusion or invitation into local hospital strategic planning and opportunities to contribute their expert knowledge to the dialogue ‘regarding policy changes and directions of the health service’. The women nurse participants each wanted to contribute but most were thwarted to ‘be visible and provide a strong voice for nursing on professional issues and decision-making bodies’ (Pinch & Della 2001:49 emphasis added).

Summary of Section 3
Discussion of the many disempowering exemplar MLWNs’ experiences presented in this section related to specific episodes from the MLWNs’ work histories. They self-managed by applying implicit strategies to resist being oppressively overwhelmed and at risk of becoming disfunctional in their job or ill. Emergent from my analysis was that the role and focus of effort by the majority of the MLWNs
were poorly acknowledged predominantly by their more senior nursing executives. The MLWNs’ experiences revealed to be located within this dominant and oppressive discourse, Bureaucratic Managerialism – Absence of Care, was a concern. For many MLWNs their expertise and contributions to their hospital’s achievements were not celebrated nor viewed as legitimate.

Within the subjectivity position of Relationship with Nurse Executive – An Uninvited Voice, the discordant power/knowledge fracture present between many MLWNs and their nursing executives showed the relationships were predominantly disempowering. These experiences seemed to exemplify what Friere (1972) ascribed as behaviour of oppressed groups deflecting oppression upon another less powerful group. In this case it was nurses disempowering other nurses and from a hierarchical vantage point. The effort by the MLWNs to inscribe the values of nursing at the organisational corporate level, by creep up/in or confrontational strategies, was shown to be predominantly stymied, principally by their positionally located nursing leaders.

This ethnography did not include nurse executives as research participants. Thus, the perspectives of this level of nurses were not part of the data nor, therefore, can definitive explanations be made as to why such relationships with MLWNs emerged as disempowering. The initial research findings, reported by Orrock and Lawler (2006), of extreme marginalisation experienced by their cohort of nurse executives in the NSW public health system was worthy of consideration in the context of the emergent insights within this ethnography. However, the insights emergent from my data analysis and discussed in this section of the chapter was particularly disconcerting. The insights partially indicated that the nurse executives to whom the MLWNs’ referred had adopted, in-part or completely, deliberately or unconsciously, the values attributed to those of a traditional patriarchal bureaucracy steeped in economic managerialism. There was a strong sense that the MLWNs’ nursing leaders demonstrated an ‘absence of care’ toward local nursing issues and toward many MLWNs as their immediate subordinates with the delegated responsibilities to enact corporate and professional agendas.
The concern by one MLWN, and supported by literature reviewed, was of the risk of a loss or demotion of the leadership of nursing if government level decisions were to restructure public hospitals’ executive staff positions that eliminated nurses from such position. The absence of care at the governmental levels was revealed to relate to nurses having minimal or no voice to influence governmental decisions about nursing executive positions within the WA public system. This disempowered state could have been juxtaposed against the efforts from the OCNO, DoHWA, to encourage nurse leaders’ engagement in dialogue related to nursing professional practice issues which were occurring at the time public hospital executive level restructuring was occurring.

In respect to the MLWNs’ experiences within this discourse one of my late journal notations provided a summation for this section, in that:

**Helen (reflective journal):**

What I notice of the MLWNs is that when the connections between them and their Nurse Executive and other more senior hospital staff is in tension then there is a seeming lack of support toward the MLWNs. The MLWNs do what nurses traditionally do – they dig deep within themselves to keep going in the face of no or minimal acknowledgement from those who are the major decision-makers. The MLWNs dig deep in order to ensure patient care is not compromised. They receive no bonuses, no prizes, minimal thanks or recognition for the significant roles they play in their hospitals. It’s almost like there is a flip-flop between despair and safe environments within their working conditions and it’s a constantly changing state.

In applying the critical social science definitions related to empowerment (chapter four, section one) it was within the Discourse of Bureaucratic Managerialism – Absence of Care that the MLWNs revealed a predominantly conscious sense of disempowerment and oppression but not that of a false consciousness.

The dominant patriarchal discourse of medicine was also revealed as an integral always-present discourse within the MLWNs’ cultural context of practice. For
several MLWNs their role involved indirect relationships with doctors, whereas, for others the medical fraternity formed important and integral relationships in their day-to-day function. Deep concern for the future of nurses rejecting core nursing values and practices for the technological low level medical tasks formed important components of some MLWNs’ experience. As a taken-for-granted discourse, Medical Science Discourse – Working the Margins, within which nurses have traditionally practised, the following section includes discussion of emergent insights from the MLWNs’ realist experiences. These experiences were located as disempowering to them as women nurses and for nursing. The discussion reflects self-managing strategies the MLWNs used to inscribe the legitimation of their expertise with doctors and graduate nurses. In addition self-managing strategies were used in their effort to work the margins in order to have the contribution of nursing practice acknowledged as important by doctors.

Section 4. Medical Science Discourse – Working the Margins

Introduction to this section
Section four presents the MLWNs’ realist experiences which were analysed as disempowering subjectivity positions and located within the traditionally dominant Medical Science Discourse.

Discourse: Medical Science – Working the Margins
- Subjectivity Positions:
  - Medical Dominated Unit – Unchallengeable Sovereignty
  - Professional Frustration – Fear of Future Loss of Nurses

As discussed in chapter three there was a plethora of nursing research which demonstrated nursing was subjugated to medicine in Australia (Chiarella 2002; Lawler 1991; Manias & Street 2001b; Street 1992). It was within the Discourse of Medical Science and related multiple and mobile subjectivity positions that insights also emerged that reflected disempowering relationships that several MLWNs experienced during the course of their day-to-day work. Analysis also uncovered the perpetuation of medical cultural dominance within the clinical nursing context.
The selection of MLWNs’ narratives in this section show examples of resistive and productive practices the MLWNs used that aimed to disrupt medical cultural dominance by confrontation and creep in/up practices.

The role of four MLWNs did not incorporate direct interaction with medical staff except through their communication with their clinical nurses. As such, these four MLWNs did not reveal specific overt oppression or disempowering experiences within the Discourse of Medical Science – Working the Margins. Four other MLWNs, however, did disclose experiencing considerable disempowering issues with some medical staff. What was more disconcerting was many instances were revealed in which the conflict/problem was not taken seriously by their respective Nursing Executive. The medically-dominated disempowering experiences within this discourse also revealed an absence of care or interest by doctors and, at times, lack of advocacy and/or dismissal by Nurse Executives toward the MLWNs within this discourse.

Within the subjectivity position of Medical Dominated Unit – Unchallengeable Sovereignty, the historical subjugation of nurses and allied health professionals to medical staff was revealed to be persistent. Many MLWNs felt marginalised as professionals at unit level wherein the medical consultants were regarded by the clinical nursing staff as ‘experts’ in nursing-related patient care decisions.

Further, from participant observation and in conversation it was apparent to me that many MLWNs worked behind the ‘real’ clinical work scene. Thus, as a consequence of their invisibility they were relegated a low priority of importance among the unit staff generally. This situation contrasted with the efforts each MLWN actively made to be visibly present at unit level. They spent considerable time fostering connections with the nurses and establishing professional relationships with doctors. This ‘presencing’ was predominantly unacknowledged as a critical component of their day-to-day work by other health professionals, including that of many Nurse Executives. The smooth operations of managing patient care units, participating in nursing handover, collaborating with doctors and allied health professionals, ensuring safe and ethical standards of nursing/patient
care practice, and asserting the need for the nursing voice in patient care decisions were fundamental aspects of this ‘presencing’.

The dominance and privileging of the doctor’s unchallengeable sovereignty, or dominance, emerged from a variety of conversation topics but mostly from my participant observations with the MLWNs. The sovereignty was exemplified by: the structuring of nurse-patient care schedule around doctor’s ‘rounds’; nurses interrupting their work to defer to the doctors’ wants; nurses accompanying doctors on their rounds but not vice versa; lack of nurses’ formal authority to question a doctor’s decision; nurses enacting doctor’s decisions but not vice versa; doctors who asserted ‘team’ leadership but did not function as a team ‘player’; patient admission/discharge determined by doctors; senior doctors controlling the unit’s budget; absence of nurses’ involvement in the development of unit strategic/operational planning; unit directors are doctors but with no managerial expertise; and the personality of the medical unit director being embedded as the workplace culture.

Disempowerment was also felt by some MLWNs by the continuing lack of interest or understanding by doctors of nursing. This was especially seen in some senior medical staff. The contribution to the overall health care service provided by nurses, inclusive of their knowledge and skills, was unacknowledged. There was a high level of invisibility of nurses. The strong impression being that the nurse existed to assist the doctor. This was the typical stereotype of the nurse as the subjugated doctor’s handmaiden.

Also located within this discourse was the subjectivity position of Professional Frustration – Fear of Future Loss of Nursing. To a lesser extent several MLWNs’ experiences revealed a deeply private concern for graduate nurses whose interests were more toward high technological practices in contrast to practices that were fundamental to traditional nursing practices.
The following discussion and critique details MLWNs’ disempowering experiences revealed as located within the subjectivity position of Medical Dominated Unit – Unchallengeable Sovereignty as integral to the Medical Science Discourse.

**Subjectivity Position: Medical Dominated Unit – Unchallengeable Sovereignty**

In this subjectivity position there were two related component experiences that are discussed below. These inherently involved exemplars of MLWNs’ self-managing strategies.

**Confronting the Dominant Medical Background**

Realist exemplar MLWNs’ disempowering experiences are critiqued within this subjectivity position as these revealed the rare occasions in which MLWNs openly confronted doctors. The MLWNs demonstrated strategies aimed at retaining their own integrity or that of other nurses against doctors who took-it-for-granted that their decisions would remain unchallenged. Data analysis revealed insights that indicated minimal change in the balance of the power/knowledge relationships between nurses and doctors. However, this was not to deny that the MLWNs also experienced healthy and professionally effective relationships with many doctors. Rather, even though nurses, acknowledged by other nurses as experts and by many doctors, have made significant advances toward best nursing practice, the status quo continued; the medical discourse was more dominant than that of nursing discourse. Nursing expertise was shown to persist as a subjugated knowledge by the sovereignty of medical dominance in patient care decisions.

The Australian health care system was similar to that of other developed countries in which medical and patriarchal values were embedded, dominated, and influenced health workers, including nurses (Chiarella 2002; Horsfall 1996; Irurita, 1990; Mason, Backer & Georges 1991; Street, 1992). Of the power of doctors to influence health reform in Australia and New Zealand, Alexander (2000) noted that traditionally it had been doctors who made decisions about health resources. Further, ‘without their cooperation, much change is unachievable’ (Alexander 2000:162).
One particular disempowering experience revealed by one MLWN provided insight concerning her confrontational productive action to openly challenge medical dominance. Her effort was an endeavour to protect nurses and patients in the face of non-consultative decisions made by a senior medical staff:

**MLWN:** The senior medical officer made so many decisions 'on the run' which affected me and my staff considerably. As a result we were expected to make changes where we had no authority. For example, instead of addressing doctors on issues for which they were responsible, memos were addressed to clinical/nurse managers! I eventually had my say in a senior staff meeting, I had to stand my ground and not let it happen. This opened a can of worms with other nursing staff, allied and clerical staff who all supported me. Some small changes were made but at least some were made. The message I got later from my nursing executive was not helpful. I wasn’t supposed to challenge doctors!

My experience with specialist nurses, like those practicing in Pain Management, Infection Control, Wound Care, and Stoma Therapy was that they applied their expert knowledge in consultative ways. They did not, however, have organisational authority to override medical decisions, as two MLWNs’ exemplars demonstrate below. The lack of formal authority for nurse experts to intervene (and alter the course for best patient outcomes) against the formal authority of doctors’ decisions could be viewed as a false consciousness about the status of expert nursing knowledge. They could not make a difference in the power/knowledge network with doctors. Further critical analysis showed that these specialist nursing roles held professional responsibility but no formal authority to intervene in unsafe, unethical or incorrect health professional practice, except that of nurses. Nursing expertise was still not adequate to breach the oppressive barriers of the dominant background discourses and to have the voice of nursing inscribed as integral and formally legitimated. The consultative nature of clinical specialist nurse’s level of authority indicated a continuance of patriarchal oppression as could be understood by one MLWN’s feeling ‘privileged’ to be ‘invited’ to speak to a doctor of her expert nursing opinion about patients’ needs:
**MLWN:** We are consultants so we're invited in [to nursing and medical practice situations], so it's actually a privilege to be invited to offer that opinion; whether it's hands-on [clinical intervention] or my knowledge. So it is quite a privilege and I don't think you can ever take it for granted that you can just go and do what you like.

The following narration from the same MLWN exemplified movement between subjectivity positions of an empowered relationship with doctors and a disempowering subjectivity position of having to re-establish her value to doctors she had not met before. As the exemplar below shows even when the nurse was a known expert in the hospital it required her to frequently re-negotiate with doctors to have her expert nursing knowledge worthy of being taken seriously:

**Helen:** I've noticed how exceptionally diplomatic you are with doctors. It feels to me like you're an insider being an outsider being on the inside.

**MLWN:** Yeah, it is. It's a lot like that. Some of the doctors I might know very well so, I don't have to go through the same steps [of developing trust and respect of nursing expertise]. Whereas with others I have to develop the relationship from the beginning. I suppose it's my experience that is probably the most important thing in that regard.

The physical space of the nurses’ station was a subtle but overt confrontation with medical dominance. From my participant observations the nurses’ station was a physical demonstration that patient care areas of hospitals were the taken-for-granted domain of nurses, with everyone else viewed as guests or visitors. It was the dominant space where nursing power was inscribed: nurses congregated to discuss and document patient needs, liaise for professional development, collaborate with ‘visitors’ such as doctors and other health care workers, and socialize. As an ‘outsider’ researcher my observation was that nurses exercised a taken-for-granted power over the way they related to non-nurses in this space. The unstated message I felt when being with the MLWNs was that the nurses’ station affirmed the principal function of a hospital – that of the provision of nursing expertise to patients. It was in this space, particularly, where the values of nursing
were subconsciously exercised and confrontationally resisted being dismissed or oppressed. Further, the corridors in patient care areas were stuffed with nurse-patient equipment because there was limited storage space but which also clearly projected the image that this was the working space of nurses.

In a less confrontational manner the following discussion refers to MLWNs’ experiences that where also located in the Medical Dominated subjectivity position. However, the discussion exemplified creep in/up strategies the MLWNs’ used that aligned with Heckman’s (1999:146) consideration to reverse Audre Lorde’s comment which was to ‘use the “masters’ tools” to dismantle the master’s house’ and thus reshape the patriarchally dominated culture to better achieve feminists’ goals. As I asserted in chapter four my stance in relation to Heckman’s (1999) proposal was that nurses’ words and actions, as women’s ways of knowing, if not so radically different to that of the dominant patriarchal language, could alter the hegemonic social and cultural assumptions.

Working the Margins
Data analysis revealed the MLWNs more often endeavoured to work the margins to resist or overcome medical dominance. Working the margins emerged as a more effective strategy for the MLWNs to enact as this approach retained good relationships with the medical staff.

Holly and Brigit, for example, showed how they worked the margins, or used ‘the master’s tools’ by fostering ‘connection, not radical relocation’ (Heckman 1999:147) with the doctors:

Helen (journal):

Holly discussed with me how, when she came to the unit, she initiated good communications with the doctors so that she could keep abreast of changes in this area of medicine, and so that she could support the nurses’ staff development. These doctors, soon, freely came to her to collaboratively discuss issues. However, Holly also indicated that some doctors were still precious in the way they thought they knew best what to teach nurses. She
used her political experience to give in to them when she felt it appropriate but also resisted on other issues.

**Brigit:** Part of my role is to take on the medical students now. They come for some of their practical experience and they work with a registered nurse. I think it's fabulous, it gives them a bit of a shock, me asking them to go and empty a bottle or a bed pan.

In a different way, *Poppy* showed the patience needed by nurses. As a strategy she worked the margins in order to effect nursing practice improvements, such as a nursing health assessment form that first needed to be approved by doctors:

**Poppy:** As a group [middle-level nurses], we can make clinical changes providing we have support, but that doesn't mean that that support will be easy to get. As an example, we were trying to implement a new assessment form which the nurses had developed. We had to take that to the senior medical doctor. Then we had to change everything to suit her/him. But we then also had to get support from other doctors. There was a power group among the medical staff - so we had to make sure that we brought that power group in. It's difficult playing the politics all the time to implement a hospital-wide change.

In contrast, *Kara* worked the margins in the following way:

**Kara:** I don't want to be in conflict with medical staff. I want to be collaborating with them so you've got to gauge how you do that in everything from that point of view.

In contrast to Manias and Street’s (2001b:135) subjectivity position of ‘the nurse as a visible go-between’, one MLWN’s expert nursing knowledge afforded her full expert knowledge by the medical consultant. *Kara’s* different and empowering scenario showed how her expertise could be integral to a collaborative relationship with a doctor and working the margins:
Helen: What I noticed when you were invited onto a medical round there was barely any conversation going on around the patient’s bed. It was as though knowledge was being transmitted [between you and the medical consultant] by mental telepathy.

Kara: We know each other well. I think you get to a certain stage where you're both seeing the same things or near enough to the same things based on your experience so that you don't have to do a lot of talking.

Brigit’s presence as a role model fostered the senior nurses present in the following situation to learn to be more assertive with doctors:

Brigit: We had one patient who was very distressed because he wanted to go home but he really needed to be in hospital. Nobody [doctors] wanted to make a decision about him so I took the lead. As the most senior nurse I can direct the medical staff to do what I want for the best patient outcome but the clinical nurses probably can't always take that kind of lead.

For Celia the workplace culture depended upon the personality of the medical directors of the units. The following exemplar revealed the always-present need for nurses to productively initiate relationships with doctors and not vice versa:

Celia: How the nurses work with the doctors depends upon who runs the units and whether good relationships can be formed. We make a big effort each time we have a change-out of doctors so that the culture in the units get set from the outset, like more collaborative and approachable . . .

Each MLWN fostered, by role modelling, expert nursing practice as one means to inspire and enhance other nurses’ practice (emancipatory and transformational intent). They were aware of the need for nurses to persistently demonstrate their clinical expertise and knowledge as the means to gain recognition by doctors. The MLWNs expressed the need that nurses always had to prove that their ‘voice’ was worthy of attention (an oppressive taken-for-granted implicit cultural construct). Doctors, (and many nurses) took-for-granted that doctors were the experts in
nursing care knowledge. The persistent lack of acknowledgement by some doctors of the relevance of nursing knowledge to effective patient management meant that nurses, including the MLWNs, struggled against this hegemonic cultural state every day. As an example, in one hospital unit the doctors resisted using integrated health care notes. This behaviour exemplified their lack of valuing of other health professionals’ expert knowledge and interest in collaborative team work, specifically that from nurses. The following is an example from one MLWN in which she demonstrated the need to constantly work the medical margins for the benefit of patients and which exemplified the marginalisation by doctors of nurses:

**MLWN:** This unit is driven by medical staff. The patients are in hospital because they need nursing care. When I talk with my registered nurses I can feel and hear them say that they don’t feel like they’re valued and that is really the biggest thing that I am trying to achieve.

As Walker (1994:165) asserted from his ethnography with clinical nurses, their place in the production of knowledge was invisible by those ‘sovereign patriarchs’. In one MLWN’s experience the *subjugation* (*objectification*) of nurses’ knowledge was dismissed by some doctors as irrelevant:

**MLWN:** The nurses on the unit had worked really hard to develop this education pamphlet, and then the consultants came in with one that had been created outside the hospital! None of our nurses had any involvement in it at all. But we were expected to give it to our patients, but it contained incorrect information!

*Misha*’s struggle to breach the medical dominance discourse showed her persistence and eventually successful efforts to argue on two fronts. Firstly, the importance of a nursing presence in the unit. Secondly for newly qualified registered nurses to gain experience in the unit:

**Misha:** It’s hard to tell sometimes if doctors are really interested or not in nursing. But, now that we have graduate nurses the medical staff recognise that
these nurses are here because they want to learn what we do. . . . It's opened
the doorway for doctors to realise what we're trying to achieve; that we're
not fossils doing the same old thing we did 20 years ago. They now
recognise that we're not handmaidens, because that was their perception as
well. Doctors don't take ownership of the area but nurses do. The nurses
strive towards improving things. I'm planning for the future, not just today.

One of the empowering strategies that each MLWN used as a way to resist the
demotivating effects of the cultural tension within which nurses were poorly valued
by the medical staff was exemplified by another of Misha's strategy of actively
making herself visible among her nursing team:

**Misha:** I'm proud of myself, the way I do get out to my nursing staff. I know my
team, I know how they're going and if they've got problems that are personal
or whatever. It takes a lot of energy just to go around the whole unit,
consistently getting to know how people are getting on, making sure they're
working well with the group and that they're being valued by that group.
Fortunately I get good feedback from the nursing staff but very rarely do
you get it from anybody else which is really quite soul destroying because
you have got the responsibility for each of the nurses.

Each MLWN had exceptionally good relations with many medical consultants, and
other doctors. Several MLWNs were particularly, acknowledged for expert nursing
knowledge. They were observed to apply Heckman's (1999) suggestions.
Heckman (1999:147) proposed that changing Background cultural assumptions
from the margins was ‘affected by connection, not radical relocation’, as shown, for
example, by one MLWN:

**MLWN:** I don't know how you measure that [expertise] but it's funny you should ask
that because one day a doctor said to me - "You've got influence around
here. What can you do about this situation?" I thought, "Mm," and it was
probably an issue that I didn't really think I had much clout to change. So,
sometimes you don’t realise your impact in the whole organisation.
As self-managing strategies that aimed to reinsert nursing knowledge and resist being unacknowledged by medical staff most of the MLWNs nurtured their self-confidence with realistic self-analysis. They also showed an increase in personal tolerance to those who may not have liked or agreed with their nursing expert opinion. Nor did they internalise such situations as a personal affront (resistive to being oppressed). Further, they demonstrated using their expert nursing knowledge (local politics) to break through some areas of medical hegemony. This strategy further nurtured an inscription of the nursing voice into medical practice and could be viewed as working the margins of creep-up/in strategy. Misha’s account exemplified these notions:

**Misha:** One head of department didn’t understand the quality standards process. It was about the time we were due to be assessed, a couple of years back now, and s/he was so overwhelmed by the whole thing that I said, “Look, I’ll go through it with you,” and s/he said, ”This is nursing jargon. I don’t understand it.” S/he was so pleased that I helped her/him which put me on the same level as her/him, as head of department. That did make me feel empowered because it made me feel that I was achieving something that none of them could do. It was good to be wanted for that.

**Helen:** And were you acknowledged for that assistance?

**Misha:** Yes. But, it's a shame that it took something that they call nursing jargon for me to help interpret for them, but it did have a good effect for a while.

Brigit’s professional relationship with many consultant doctors indicated how successful she was at ‘working the margins’ and how they supported her when confronted by more junior doctors who had not yet learned to respect her nursing expertise:

**Brigit:** Sometimes I believe I'm walked over. For example, I had a registrar who thought he was somebody pretty important. But I think someone must have said something to him because all of a sudden he was quite nice to me and I don't think he realised the position that I held or the respect I get from many consultants.
The above discussion and MLWNs’ exemplar experiences revealed that in the MLWNs’ day-to-day working culture they experienced a commonality of persistent domination within an always-present discourse of medical sovereignty, but in varying ways. The discussion showed that not all doctors related to nurses in oppressive or disempowering ways. There were, however, no experiences where doctors endeavoured to empower nurses as professional equals. Strategies by the MLWNs that aimed to breach the dominant medical science discourse were focused within the notions of creep-in/up, or working the margins. There was limited success in having nursing expertise or values inscribed as part of doctor’s taken-for-granted culture of the health system.

One MLWN’s experience was presented which showed that her Nurse Executive was positioned alongside that of the doctors. The Nurse Executive had chastised the MLWN for openly confronting a medical decision. This exemplar was indicative of a dominant power/knowledge relationship. It was doubly disempowering and oppressive for the MLWN because she was distressed by having to resort to confrontation in order to have her voice heard, which was then further subjugated by her own nursing professional superior.

Discussed below is the last of the disempowering subjectivity positions. A few references were made by the MLWNs of their concern that some nurses reject critically important aspects of nursing practice to embrace technological tasks that were once the domain of doctor’s scope of practice. The subjectivity position of Professional Frustration – Fear of Future Loss of Nursing was located within the dominant Discourse of Medical Science – Unchallengeable Sovereignty.

**Subjectivity Position: Professional Frustration – Fear of Future Loss of Nurses**

Three MLWNs experienced a subjectivity position of Professional Frustration – Fear of Future Loss of Nurses that related, in particular, to concerns about the attitudes and practice focus of some graduate registered nurses. I located these experiences as disempowering and within the Discourse of Medical Science not because they were oppressive to the MLWNs, per se, but because they felt
disempowered to influence a change in these graduates’ appreciation of the values of nursing. Analysis revealed that the MLWNs’ concerns were that the graduates wanted to practice within the Discourse of Medical Science instead of within the Values Attributed to Nursing Discourse. Many graduates’ interests, as the MLWNs’ experienced, were toward technology and interventionist skills/tasks (such as: insertion of IVs, plastering, defibrillation, suturing, and the like). The MLWNs also experienced many graduate nurses as highly resistive to working the ‘usual’ nursing shifts and who preferred to function as independent non-collaborative decision-makers. However, there was also a high recognition by the MLWNs of the failure by the ‘old guard’ hospital trained nurses, many holding very senior leadership positions, to effect innovative practice models that met the new workforce demands.

The following exemplars came from different MLWNs but because their comments may identify them I have used the generic term MLWN:

**MLWN:** The university nurses are different to the nurses like me who were hospital trained. It may just be the generation difference, but they are not as indoctrinated like we are – they have a very different mind-set, they don’t seem to be as committed, like, they’ll stay for a certain period of time and then move on. They’re not happy with the shift work and they prefer to do the technical stuff rather than the mundane nursing work. So, it also makes it difficult to create a ‘family-friendly’ rostering system.

**MLWN:** I didn’t like my training, but we had great friendships. I think the grads today miss out on a lot of the kinds of fun we had – you know, we used to hide pillows in the bed, and oh, gosh, what we didn’t do . . . but I think my training taught me how to cope, I mean, I am a survivor . . .

**MLWN:** A nurse made a comment to me recently that the graduates are educated in university to be autonomous practitioners and to be creative, but, she said, ‘When you come out, the nurses in the wards are hospital trained, and they tell you how to do your job, and when you come out from handover you
Celia identified a significant risk when a unit has a large nursing establishment. In this situation there were minimal opportunities for nurses to get to know each other and this negatively impacted upon the notion of ‘team’ work. It was especially difficult for the nursing shift coordinator. Holly raised her concern about the very traditional ward/unit routine practices of nursing activities, like ensuring that bedmaking and patient washes were completed before the 9am consultant’s rounds. Holly’s concern was that such antiquated practices did not fit with patient-centred care philosophy. While patient-centred care was a feature of contemporary nursing education, in reality practices were centred around the doctor. The MLWNs commented that the new nursing workforce would not tolerate such a mismatch between education and practice. It was argued that they would show their intolerance by leaving the profession, as was noted in the DoHWA ‘New Vision, New Direction’ report of 2001 (Pinch & Della 2001).

As a final indication of the MLWNs’ fear for the future of nursing as a disempowered reality state and recognition of nursing’s subjugation was Celia’s comment:

*Celia:* I think nursing is a fabulous foundation for so many different career launches . . .

**Summary of Section 4**

For the MLWNs their multiple and dynamic subjectivity positions of being in the Discourse of Medical Science was revealed as disempowering and wearisome. It was a familiar cultural context and understood as a taken-for-granted nursing experience.
Firstly, the MLWNs’ exemplars showed the Discourse of Medical Science persisted in being privileged over that of the Nursing Values Discourse, especially at the local patient care level. Even for senior experienced nurses, like that of the MLWNs, they were rarely overtly respected for their knowledge and expertise by the medical fraternity. Few MLWNs’ realist exemplars showed that doctors actively sought consultation from nurses, but, in contrast, nurses persistently needed to subversively negotiate with doctors to gain ‘kudos’.

Further, more often than not, doctors assumed leadership roles at the local clinical patient level which was unchallenged by most nurses in the clinical practice setting. At the local unit level it was the doctor who was the organisationally authorised leader of the ‘team’ but who did not engage other health professional experts, like that of nurses, in the unit’s overall short or long term planning needs. Further, the MLWN was rarely credited for her significant contribution to the successes achieved for the unit or the hospital.

For three MLWNs, in particular, their personal efforts to professionally connect with doctors, and thus raise the profile for the legitimating of nursing knowledge, provided insight into their creep in/up empowering strategies. Not only was nursing expertise poorly acknowledged but there was also a high level of medical staff resistance to proactively support professional nursing agendas and was another form of marginalisation and subjugation.

Functioning in an always-present ‘sovereign’ medical hegemonic culture provided further insight as to the difficulty for MLWNs to breach this discourse to have nursing values genuinely inscribed into the doctor-nurse patient care cultural context.

A further indication of disempowerment was the inability for the MLWNs, as senior experienced nurses, to influence the new generation of university educated registered nurses to practice within the discourse of nursing values. What the MLWNs revealed was their experience of many graduate nurses who viewed the reality of nursing practice as mundane and unimportant, in preference to the ‘high
tech’ of ex-medical authorised tasks. Several MLWNs expressed this shift toward medical practice as job creep that further devalued the basic but critically fundamental practice of nursing. My view of this contextual shift was that it seemed there were increasing numbers of new and experienced nurses who were exhausted by the constancy of competing to inscribe nursing’s fundamental care value within alternate and dominating discourses, like that of medical science and managerialism, discourses devoid of care for nurses and their contribution to the basic premise of the best health care for patients.

Summary Comments on the Chapter
This chapter centred the multiple, mobile, unique and different voices of the eight women nurse participants in this ethnography. The discussion and critique integrated the research aim and the four particular objectives within the methodological context informed by feminist postmodernism. As a forum to valorise these women’s ‘unsaid’ this chapter demonstrated that women’s knowledge, as that of women nurses, is valid and legitimate.

In the speaking of their reality of practicing within the cultural context of WA public metropolitan hospitals each MLWN revealed values deeply embedded and enacted in their roles. Those particular personal and professional values when analysed applying a multilayered and multifocal critical lens informed by principles and perspectives of an integration of feminism and postmodernism revealed the MLWNs practised within three always-present competing discourses, each discourse constructed upon different and opposing values. The impact of endeavouring to function within always-present discordant cultures, such as the MLWNs’ preferred but oppressively subjugated Nursing Values Discourse and the dominant and patriarchal Discourses of Bureaucratic Managerialism and Medical Science created different states of being for the MLWNs which were viewed as subjectivity positions. The ways each MLWN chose to function within the different and non-fixed subjectivity positions were further viewed as self-managing strategies that fostered her self esteem and confidence to stay in her job and empowered her to centre her advocacy for nurses, nursing and patient care. Self-managing strategies were revealed to be present for experiences identified as
empowering, transformative and liberatory, disempowering and oppressive. It was not either/or strategies, but rather fluid and mobile, tacitly taken-for-granted decisions. Nor were the subjectivity positions viewed as fixed but as mobile, transitory and at times simultaneously experienced.

My trifocal data analysis revealed six individualised unique frames of insights for each MLWN that were affirmed as relevant and accurate. Many of these insights were common to each MLWN and in collating them, and retaining unique differences, a deeper understanding was reached of the lived experience of women nurses in middle-level public hospital positions. The insights revealed the ever-present network of power/knowledge relationships with which each MLWN implicitly enacted the feminist maxim of politics at the personal level.

In the next chapter I reflect upon the journey and meanings I gained from undertaking this research and suggest the benefits to a broader nursing and social science research community. Those aspects of the research process that may have ‘fallen through the cracks’ will also be discussed.

In the next chapter, I also reflect upon the value this ethnography may have contributed to the local and national professional nursing dialogue as a partial response to key reports: The Report of the West Australian Study of Nursing and Midwifery ‘New Vision, New Direction’ 2001 (Pinch & Della 2001) and National Nursing and Nursing Education Taskforce Report 2002 (N³ET) (Department of Education, Science and Training 2002). Emerging from this discussion I also offer options for future research.

In keeping with my postmodern non-authorial interest I did not presume to suggest what benefits the MLWNs gained as a consequence of participating in this ethnography. However, from my feminist perspective, I could only hope that my demonstrated efforts to pursue research had been with them and not on them.
Chapter 7.
Concluding Remarks and Where to from here?
Introduction

The final chapter of this ethnographic thesis aims to evoke optimism for women nurses and other women who function in middle-level bureaucratic roles that integrate corporate and professional responsibilities. Amidst a culture of competing taken-for-granted sociopolitically constructed discourses, present within the two ethnographic public hospital sites in WA, MLWNs in this sociological ethnography showed the value to themselves of their empowering workplace nursing values and practices that they endeavoured to inscribe on a day-to-day basis.

In chapter six discussion and critique focused upon the emergent insights from data analysis incorporated with realist exemplars from the eight MLWN participants. Chapter six, therefore, formed the principal focus of the aim and objectives of the thesis as that of the voices of the eight women nurse participants.

In this closing chapter aspects about the ethnographic study are discussed from my critical reflective researcher position. Particularly, this chapter focuses upon implications and future consideration at the local, national and international nursing professional practice and research levels, as well as for feminist social science. My discussion relates to specific aspects of emergent insights from the MLWNs’ experiences which evoked optimism for the future. It also refers to insights which were disconcerting, those being the marginalisation and patriarchal practices by some nurses in executive positions and doctors.

Research outcomes from critical qualitative research, like this ethnography, which was framed within an integrated feminist postmodern methodology, was acknowledged to be partial, historical, localised and incomplete. Hence, no one truth or theory was proffered as representative of the reality of the MLWNs. The data was viewed as a slice-in-time of the MLWNs’ lived experience and, therefore, not fixed or total. Multiple alternative insights may have emerged given different
ethnographic participants, ethnographic sites, methodology and data collection and analytic processes. However, the multi-dimensional methods applied in this ethnography revealed insights worthy of being celebrated and widely disseminated within the nursing professional arena, especially as these were accepted as meaningful to the eight women nurse participants. Further, it was anticipated that the insights may resonate with other nurses, in that they too may recognise the similarities of their own thoughts, feelings and experiences.

There are four sections to this chapter. The first section represents a summary of pertinent methodological premises that informed the research to demonstrate the connectedness between the research focus and objectives. The value of the innovative multi-phased analytic design that I developed to apply to the ethnographic data is also summarised in this section. I propose this analytic method to be of importance to the body of knowledge within critical social science research. The second section presents particular implications from the ethnography with associated insights for future research and education opportunities. In the third section some important research process implications for the MLWNs and myself as researcher and participant observer are commented upon. I also identify aspects of the research process that may have fallen through the cracks. The fourth section outlines the ways I propose to disseminate the knowledge gained from this ethnography.

The first section, as below, briefly summarises the interconnection for this ethnography of the research design with the research objectives.

Section 1. Alignment of Research Design with the Research Question and Objectives

This research contributed to the knowledge base of scholarly work that existed about nurses, women nurses specifically, concerning the meaning they made of their experience of practicing in the confluence of middle-level public hospital corporate and professional responsibilities. The eight MLWNs held different senior merit-selected roles in the public WA hospital system and were responsible, in
different ways, to enact the goals of the hospital’s corporate agenda and foster and support the professional nursing agenda.

Chapter six presented in-depth discussion and critique of the ethnographic emergent insights and which was principally connected with the multiplicity of voices of the MLWNs of their lived experience. As an overview this integrated feminist postmodern ethnographic research revealed multiple, mobile, similar and different subjectivity positions for the MLWNs which reflected a fluidity of their states of being. Their positively expressed experiences were viewed as empowering and negatively expressed experiences as patriarchally disempowering and oppressive. Their states of being, or subjectivity positions, were further reflective of personal, professional or corporate experiences and within which were assumed to inherently have incorporated self-managing strategies and implicit knowledges. Consideration of discursive common assumptions related to power/knowledge relationships that framed the MLWNs’ cultural context, as socio-politically constructed discourses, revealed three always present discourses. The discourse of nursing values was identified to be empowering for the MLWNs but subjugated by the patriarchally dominant and principally disempowering discourses of bureaucratic managerialism and medical science.

The research focus and objectives located the research within the contemporary critical postpositivist genre. The research did not seek to quantify attributes, characteristics, qualities or levels of satisfaction of this professional workforce group, or to create a generalisable theory. Further, the intent was not to represent myself as the authorial expert of other nurses’ experiences.

As Denzin and Lincoln (2000a) noted of postpositivist research that it located the researcher in the natural world of others and attempted to understand the meanings people made of things and phenomenon. Being in the world of MLWNs, to gain a comprehensive understanding of their cultural context, identified ethnography as the most suitable methodology and method for this research. Ethnography as both methodology and method was detailed in chapter four.
My ontological stance, informed by my experience as a woman nurse, was a concern for women nurses’ gender-biased subservient position and subjugation of their knowledge in the health care system. This concern, thus, located my epistemological research interest within a feminist genre. Literature review, as critiqued in chapter three, supported my stance that nursing was historically dominated by the patriarchal medical discourse and more recently also by patriarchal bureaucratic managerialism. One principle feminist premise, inherent in my ontology, was that patriarchal power was a social construction in which men wield more power than women because men established what was valued in society (Flax 1999; Glass 2000). My research interest, as a feminist emancipatory intent, was to provide a safe forum with the MLWNs to uncover and foreground their reality as ‘unsaid’ (Glass 2003b:189) unique voices of their experiences. Further, to acclaim and valorise as legitimate their local and particularised knowledge. Inherent in my emancipatory interest was to critique their experiences, through the feminist oppression narrative lens, to reveal the ways that these individual women nurses’ self-managed being in the hegemonic patriarchal discourses. This thesis, thus, speaks out for these women nurse participants, as their own subjectivities, and does not speak for them as objects of research.

Affirmative optimistic postmodern perspectives also aligned with my interest to foreground women nurses’ differences, multiple realities, multiplicities of voices and the power relations that existed in their day-to-day practice. I viewed these perspectives as legitimate sites for epistemological insights. Postmodern perspectives supported a re-focusing and challenge of taken-for-granted cultural assumptions inherent in the discourses that constructed the social world. This also included those assumptions that constituted the marginalised and subjugated, like that of nurses. My critical feminist research interest paralleled with postmodernist perspectives was to critique how individual MLWNs were either inscribed or resisted being inscribed in the dominating discourses. Further, I was drawn to the postmodernists’ perspectives that rejected the modernists’ essentialist concept of the dichotomous power-differential constructs of subject/object. Instead, postmodernism elevated ‘the subject to be studied to a position of equality with the
ethnographer’ (Roseneau 1992:60). This feature also aligned with feminist research practices of non-hierarchy, reciprocity and reflexivity.

The features of feminism and postmodernism, as described above, articulated with notions from Glass and Davis’ integrated methodology which particularly informed the ethnographic research methodology and which focused upon:

Acknowledging each woman’s individual and unique sociopolitical experience within their own particular context; validating the difference and diversity of perceptions within that context; recognizing the impact of the “oppression narrative within each woman’s “everyday” life”; and “creating opportunities to deconstruct each individual woman’s stories regarding her experience. (2004:83 emphasis in original, also quoted in chapter one)

It was therefore planned that by framing the research focus within an integrated feminist postmodern ethnographic paradigm the results would demonstrate a strong contribution to the social science and nursing research and practice discourses. The thesis addressed the research intent, research question and its four inter-related research objectives. The emergent insights provided unique, different and diverse understandings of individual MLWN’s experiences as well as some important collective insights. The multilayered emergent insights reflected the interconnectedness of the research question and objectives, as listed below,

**Research Question**
What meanings do middle level women nurses (MLWN) attribute to their experience of practicing in WA public hospitals?
Research Objectives

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<tr>
<th>Research Focus</th>
<th>Research Objective</th>
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<tr>
<td>1. Experiences</td>
<td>➢ To explore and reveal issues (experiences) that are common, different, unique and exceptional that foster (empower) and constrain (disempower/oppress) the participants’ personal, professional and corporate efforts toward their own empowerment, emancipation and transformation.</td>
</tr>
<tr>
<td>2. Self-Managing Strategies</td>
<td>➢ To explore and reveal ways that the participants create opportunities within their work setting for enhanced self-management.</td>
</tr>
<tr>
<td>3. Power Relations</td>
<td>➢ To describe and critique the participants’ perceptions of the impact (power relations) on them of the hospital’s organisational culture in regards to their personal, professional and corporate responsibilities.</td>
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<tr>
<td>4. Discourses</td>
<td>➢ To review and critique the discourses (common assumptions) that frame the practice of Middle Level Women Nurses.</td>
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Four quotations provide a closing perspective of the extensive methodological influences I drew upon that informed my research process and that facilitated the revealing of unique and different insights about the research participants' ways of being in their practice setting and of their implicit knowledges: 1. Lather’s (1991c:xv) feminist emancipatory research notion that ‘in our action is our knowing’ and her postmodern feminist oppositional stance to challenge ‘the legitimacy of the dominant order and break its hold over social life’. 2. Manias and Street’s (2001b:131) interpretation of Foucault’s notion of the interrelationship between power and knowledge in that ‘knowledge is an instrument and technique of power relations’. 3. Weedon’s (1999:102) poststructuralists’ explanation (appropriated to postmodernism for application in data analysis) that ‘language does not reflect reality but gives it meaning. . . and, as such, [is] always historically and culturally specific’; and 4. Richardson’s (1991:31) postmodernists’ interest was ‘to look for that which is absent, minimized, or silenced, and move it to the center of the discourse’.

An extensive literature search, as critiqued in chapter three, of nursing and social science research revealed scant methods suitable to apply to the research objectives or research informed by integrated feminist postmodernism. The unique
and recent nursing research method, designed by Glass and Davis’ (2004), incorporated a trifocal analytic method inclusive of ‘realist analysis, an oppositional anaysis (deconstructive moment), and a postmodern reconstruction’. Glass and Davis’ (2004) analytic model informed the evolution of the multiphased multi-lens’ methods I developed to apply to the ethnographic data collected with the MLWNs. The multi-phased trifocal data anlaysis process was explained in detail in chapter five and summarised in Table 33. ‘Ethnographic Multi-Phased Analytic Process Applied to the Data’. A model of the method was also provided in Figure 1. ‘Ethnographic Research Analytic Method’. The analytic processes and model were developed for this ethnography and integrated realist, critical feminist, and feminist postmodernism analysis. The analytic methods particularly incorporated a modified set of Lather’s (1991b) poststructuralist/postmodern deconstructive feminist validity criteria and Foucault’s (1980) postmodern power/knowledge relationship notions. The rigour and validity of this innovative analytic process could be evaluated against the numerous criteria proposed by eminent scholars and sociological researchers as detailed in chapter four and summarised in Table 11. ‘Examples of critical theoretical validity criteria’. It could also be further supported by the audit trail as detailed in chapter five. The feminist research principle of inclusivity was applied by my use of multiple member checks which provided meaning to the MLWNs and confidence and credibility of the emergent insights and which also supported the research validity and audit trail.

What was revealed by the application of my trifocal analytic methods were six frames of individual and collective insights of the MLWNs’ experiences, as shown in chapter five and the emergent insights discussed in chapter six. The implications for this new analytic process was that it added to the body of qualitative research knowledge, in general. It particularly contributed to critical social science and emancipatory nursing research. The analytic phases, as applied to this ethnography, may be of practical assistance to other critical researchers. I suggest that this process can support the critical researcher who seeks to explore multiple layers of inter-sectoring insights of the lived experiences of individual’s lives. It also foregrounded participant’s multiple realities and voices.
In the next section below, I selected key ethnographic insights within which to locate my proposed future research interests and propose the implications of this research.

Section 2. Research Implications and Future Research Possibilities

Implications of the Optimistic Emergent Insights
The multiple analytic processes applied to the ethnographic data of the eight MLWNs revealed insights which were detailed and critiqued in chapter six. Discussed below are a number of key implications of the emergent insights that I considered highly pertinent within the context for future nursing practice and research.

Of particular note to the nursing profession, locally, nationally and internationally, were emergent optimistic insights worthy of celebration. These included the revealing of a range of MLWNs’ self-managing strategies and implicit knowledges. These strategies and knowledges were embedded as personal and locally directed sociopolitical efforts they applied to survive and thrive in their jobs. Further, these were integral to their resistance to succumb to alternate oppressive patriarchal discourses. The MLWNs’ unique self-managing strategies sought to subvert ‘oppressive structures’ (Code 1991:289). They each endeavoured to disrupt the status quo disempowering power/knowledge relationships. They also, each, fostered the inscription of nursing values into the taken-for-granted and always present dominating hegemonic cultural discourses of bureaucratic managerialism and medical science. The MLWNs’ principal nursing ethics-in-action were empowering, nurturing and valuing political motives directed to overcoming or preventing injustices toward nurses and patients at the local level of practice. The MLWNs’ implicit knowledge was exemplified in how they self-managed the complex and plurality of competing networks of power relations on a moment-by-moment basis.
The MLWMs were embedded in the discourse of Values Attributed to Nursing – Between a Rock and a Hard Place and was common to each MLWN. It was within this discourse that they also persistently resisted being inscribed into either of the two identified dominating patriarchal discourses. This discourse was subjugated to the two other discourses that were also taken-for-granted cultural contexts of their practice. The MLWNs' four empowering subjectivity positions identified within this discourse included: Nurse Advocate – Passionate Connection; Patient Advocate – Prime Focus; Self - Different in the Moment; and Relationship with Nurse Executive – An Invited Voice. In part, these empowering insights can positively contribute as responses to recommendations made in The Report of the Western Australian Study of Nursing and Midwifery ‘New Vision, New Direction’ 2001 (Pinch & Della 2001).

Positive Implications of the Ethnography to the WA Nursing Profession

An important implication of the research related to workforce issues as identified in The Report of the Western Australian Study of Nursing and Midwifery ‘New Vision, New Direction’ 2001 (Pinch & Della 2001) report. The MLWNs embodied nursing values, as shown, for example, by their principal nursing focus towards empowering nurses to achieve good patient care. As shown from this ethnography, retention of nurses was fostered where the MLWN, as managers and expert advisors of nurses, practised nursing ethics-of-care within an empowering model. Further, each MLWN centred nursing values within the tensions of more dominating discourses. The implications of these emergent insights resoundingly evoked, for me, appreciation that nurses whose values aligned with those of the MLWNs were the most appropriate people to be in supervisory, managerial or expert positions to empower and nurture clinician nurses’ ethical practice framed and focused upon nursing values.

Another important implication of this ethnography related to concern of the poor image and status of the nursing profession as identified in The Report of the Western Australian Study of Nursing and Midwifery ‘New Vision, New Direction’ 2001 (Pinch & Della 2001). The respective recommendation from the Report was that ‘nursing and midwifery leaders must ensure a cultural change occurs that
empowers nurses and midwives to value each other within the profession’ (Pinch & Della 2001:27). The MLWNs, in this ethnography, were revealed to create an empowering workplace culture for nurses. They were also resistive to oppression by other dominant values, such as a principal focus upon fiscal constraint. These insights were a positive demonstration of achievement of the Report’s recommendation as exemplified by the MLWNs and worthy of being publicly and professionally acknowledged and celebrated.

Further to the above, the implication of the positive empowering practices the MLWNs applied to their day-to-day work further related to another recommendation in that nurses need to value each other (Pinch & Della 2001). The notion of nurses valuing each other aligned with the importance and empowerment felt by the MLWNs of their informal relationships with like-minded colleagues. At a local level, these insights showed support for feminists’ emancipatory practice of women’s consciousness-raising conversations. Although not identified by the MLWNs as a feminist practice, each MLWN found safe and trusted support with friends of like-minded values with whom they could disclose empowering personal and professional successes and disempowering problems. The MLWNs informal get-togethers were vitally important for each MLWN as a self-managing strategy. It was at a deeply personal level that being in the presence of colleagues facilitated their speaking out of ‘unsaid’ (Glass 2003b:189) without fear of criticism or humiliation. They also felt trusted to speak of experiences that could not be confidently disclosed to their nursing supervisor. There was solidarity among their collegiate group. Within this close relationship network the personal impact of disempowering experiences could be dissipated and their self-esteem restored. Such emancipatory transformations that, in my opinion, could be likened to the feminist maxim of the ‘personal is political’ (Glass 2000:355).

A different implication of the research related to the revealed empowering leadership behaviours shown by the MLWNs as these aligned with key features of Taylor’s (2005) culture-building leadership model. Taylor (2005:xv) proposed that the leader be ‘the best player for [their] team’. Further, the MLWNs’ embedded nursing values could parallel the words of Eales (in Taylor 2005:xiv) in that, ‘it is
about who you are, the values that you endorse as an individual, the embodiment of those values in the way that you live your life, and the tradition that you pass on to the next generation’. Each MLWN viewed herself, in the multiplicity of subjectivity states, as passionately connected to nursing. This passionate connection to the profession, also embodied the way they fostered a healthy and empowering workplace culture for nurses. These insights have implications for nursing leadership recruitment, leadership education, and leadership practice, in that passion for one’s work was a characteristic, shown by the MLWNs, to be inspiring and which permeated their nursing workplace culture.

There are also research opportunities in relation to the empowering models of Scope of Nursing Practice and Decision Making, such as that introduced by NBWA (2005) in WA. Although this practice model was not a prominent aspect of the MLWNs’ experiences, it was being implemented at the time of data collection. Research into the impact of this practice model upon nurses themselves, inter-nurse relationships, and of nurses’ perceived reputation of their profession could further identify benefits for nursing workplace culture-building practices and nursing recruitment drives. A prominent research question, in relation to the model, relates to how effective is this model upon empowering nurses?

**Other Research Options Relevant to the Empowerment Ethnographic Insights**

Emergent from the empowering insights are potential implications for further research, both qualitative and quantitative in design. Firstly, a worthwhile pursuit would be to further investigate in-practice strategies nurses use to empower themselves and other nurses and that challenge or resist the status quo of patriarchal dominant disourses. Knowledge emergent from further research, inclusive of nurses of either gender, whose role is in middle-level or executive positions in public health care organisations, may contribute to deeper understanding of options that support the attraction and retention of nurses.

Secondly, future research would be pertinent to more deeply understand the value for senior women nurses of the personal and professional implications of their
engagement in informal colleague-conversations. This focus would be akin to feminists’ research into consciousness-raising group processes.

A third notion for future research relates to the value gained, for educational and employment/promotion purposes, of investigating the practical ways that nurses in leadership positions enact nursing values. The research could be framed as that which demonstrates their being ‘the best player for [their] team’ (Taylor 2005:xv).

Further, research is needed that seeks to identify what personal and professional competencies are reflected in the skill of creating and sustaining an empowering culture. In addition, valuable insights may be revealed from research that explores the contribution a professional’s passion for their respective profession brings to their workplace culture.

**Implications to the WA Nursing Profession of Disempowering Ethnographic Insights**

The thesis also revealed insights that showed many of the MLWNs’ experiences to be marginalising and oppressive, in unique and different ways. The overarching patriarchally dominant Discourse of Bureaucratic Managerialism Discourse - Absence of Care incorporated three disempowering and oppressive subjectivity positions: Relationship with Nurse Executive – An Uninvited Voice; Limited Authority – Marginalised Expert; and Government Employee – The Silenced Majority. The most disempowering and oppressive subjectivity position was identified to be the relationship most MLWNs’ experienced with their nurse executives.

The potential implications of the particular insights of the subjectivity position, Relationship with Nurse Executive – An Uninvited Voice, showed deeply disturbing problems that mimicked unhealthy nurse-nurse violence. Inter-nursing violence was critiqued in chapter three and which was noted to be inherent in most MLWNs’ nursing culture. The MLWNs’ self-managing strategies indicated their aversion and resistance to bullying by nursing supervisors. At the same time there was awareness and understanding that such behaviour may not necessarily have been
typical for those nursing executives but which was still unacceptable behaviour: it existed and needed to be revealed.

The implications of the revealed localised disempowering and oppressive insights for the MLWNs in respect to relationships with their nurse executives supported concerns as previously noted within The Report of the Western Australian Study of Nursing and Midwifery ‘New Vision, New Direction’ 2001 (Pinch & Della 2001). The implications reflect that, at the nurse executive levels, there were serious problematic executive level inter-professional relationships with the MLWNs. Further, during the ethnographic data collection period the efforts by CNO, DoHWA and CEO, NBWA, to engage and foster effective nursing leadership practices was not reflected in the MLWNs’ experiences. Further, the implications of these disturbing insights for the MLWNs highlighted their feelings of isolation and marginalisation by people within their own profession; nurses who were in the highest leadership positions within their respective hospitals.

The pressure of fiscal constraint and governmental decisions were viewed by many MLWNs to negatively influence the behaviour of some nurse executives’ relations with them, but not all. From research results, like that from Irurita (1990), Lewis (2001) and Orrock and Lawler (2006), Australian nurses in executive positions have been shown to experience deeply troubling marginalisation, isolation, and inadequate mentoring and support. Although not a focus of this ethnography, it could be argued that these research findings indicated the position held by nurse executives also resulted in relationships with many MLWNs that they experienced as disempowering and oppressive. However, of the risk that some nurse executives may have embedded patriarchal oppressor values (Friere 1970), like those values more prominent in managerialist discourse, Panduranga-Bhatta’s (2004) comment is pertinent. Panduranga-Bhatta (2004) raised the concern that when a leader neglected or compromised their moral values a culture of cynicism became apparent.

On the other hand, those MLWNs whose expert clinical knowledge was acknowledged by their respective nurse executives talked of empowering
relationships that were nurturing and inclusive. This ethnography did not seek to identify underlying reasons for the differences experienced between MLWNs in respect to their relationship with Nurse Executives.

Future Research Options Relevant to the Disempowering Ethnographic Insights

Research that focuses upon women in leadership positions, such as nurse executives, emerged as a critically important priority. For example, qualitative research questions like the following may reveal valuable knowledge: In what ways do cultural discourse constructions influence nursing leaders to behave in empowering or disempowering ways with their subordinate nurses? What do women nursing leaders need in order to support their enactment of nursing values as they also enact their executive managerialist roles?

With the recent Nurse Practitioner legislation across different States of Australia there is fertile ground for research with nurses who take up these expert clinician roles. As an example, opportunity arises to explore whether Nurse Practitioner’s expert nursing knowledge is also accompanied with enhanced legitimation of nursing knowledge by nurses, doctors and health administrators. In addition, critical research that investigates power/knowledge relationships between nurse executives and Nurse Practitioners may contribute toward better understanding of leadership practices at these senior levels in the nursing profession.

Notwithstanding possible explainable aberrations by the MLWNs’ Nursing Executives that were linked with the disempowering experiences, the seriousness of the impact upon the MLWNs of the bureaucratic managerialism discourse has far reaching professional nursing implications. One particular implication was that for the MLWNs, each attributed very high importance to their need for empowering, trusting and caring relationships with their respective nurse executive on a regular basis. As the critical leadership link between enactment of the corporate agenda and maintenance of their professional nursing agenda most of the MLWNs experienced, in varying ways, with their nurse executive isolation, invisibility, marginalisation, humiliation, and bullying and which emerged as an absence of
care. There was not an inspiring or celebratory culture within which the MLWNs practised with most Nurse Executives. The notions of ‘absence of care’ and ‘uninvited voice’ by nurses to nurses were deeply troubling, but not a new revelation as was shown from the literature reviewed in chapter two. What was new was the uncovering of self-managing self-reflective strategies, along similar concepts of nurses’ emotional intelligence (Glass 2007), that the MLWNs created in order to be their own best critical friend and to be proactive with like-minded colleagues. These kinds of personal and same-level practices need to be further explored.

In addition, the ethnography revealed that most of the MLWNs were an untapped expert knowledge resource whose contribution to the public hospitals’ corporate agenda was poorly recognised and, as such, not acknowledged. At a local public hospital level, this ethnography supported the value of middle-level nurses’ inclusion in local unit and organisational strategic planning, nursing recruitment and retention problem-resolution forums, and strategies to support patient-centred health care practices. Instead of ‘keeping them in the dark’, as was revealed by many MLWNs, they wanted to actively contribute to corporate and professional dialogue and wanted to support their nursing supervisors as ways to reduce being between a rock and a hard place.

Future research that exposes organisational or supervisor practices that victimise or harass nurses may prove to be a fruitful endeavour. Of particular value would be research that takes further Glass (2007) and Glass and Davis’ (2004) nursing research outcome notions of hope, optimism, resilience and the reconceptualised notions of vulnerability within the context of executive and middle level nurse-nurse disempowerment practices.

In addition, there are qualitative and quantitative research opportunities related to investigating comparative practices of nurses in middle-level positions against middle-level personnel in multi-site health care organisations and in non-health care organisations. The particular focus could be upon scope of roles and
accountabilities and the perceived or actual contribution such positions have upon the success of organisational goals and vision.

The always-present tensions of the different values between the women nurse participants’ Nursing Values Discourse and the Bureaucratic Managerialism Discourse will not be easily reconciled at the local practice level and can be assumed to problematically persist in the future. Fiscal constraint is unquestionably an accountability relevant for all health professionals. However, there is further need for exploration to identify strategies whereby health professional values can be retained at the same time as achieving a ‘win win’ outcome with fiscal rationalist values. The unfolding events within NSW whereby senior executive and middle-level nurses were being replaced by generic managers (Orrock & Lawler 2006) clearly exemplified the managerialist movement overtly eliminating nurses, not just that of marginalising nurses, and therefore devaluing nursing values at high organisational levels. The recent extensive consultancy undertaken by Mary Chiarella and Cecilia Lau and reported in the First Report on the Models of Care Project (NSW Health 2006) demonstrated exciting directions that promote the value for nurses of their innovative clinical models of practice in ways not previously explored or valorised.

Of the embedded managerialist discourse shown to exist as the dominant and patriarchal cultural construction for the MLWNs there is clearly a need for nursing research to investigate the potential impact upon professional nursing leadership. As this discourse gains more dominance one quotation from ‘The Nurse Manifesto’ is posed as a recommendation to all nursing leaders of the need ‘to pause, reflect and call for change’ in order to disrupt, trouble and reverse:

The idol of the current health care system symbolized by achieving measurable outcomes in an economically feasible manner in the shortest amount of time, at the expense and depletion of even more valuable resources such as caring, understanding, real human connections, and spiritual and physical renewal. (Cowling, Chinn & Hagedorn 2000:frame 6)
The third and traditionally patriarchally dominating Discourse of Medical Science - Working the Margins as experienced by the MLWNs incorporated two disempowering and oppressive subjectivity positions: Medical Dominated Unit – Unchallengeable Sovereignty; and Professional Frustration – Fear of Future Loss of Nurses.

Drawing from Heckman’s (1999) feminist notions for disrupting medical hegemony, the MLWNs’ self-managing strategies revealed mostly creep in/up strategies but with only short-term gains. Few MLWNs experienced sustained professional recognition of their expertise by doctors. There was a persistent requirement for them to demonstrate to doctors their worth as expert clinicians. Of the expanding nurses’ scope of practice and decision-making (NBWA 2005) and the emergence of Nurse Practitioner roles there is opportunity for research that investigates to what extent and how sustainable is nursing expert knowledge and practice legitimated by the medical profession. There is high optimism that these significant nursing practice changes may contribute to the achievement of part of The Report of the Western Australian Study of Nursing and Midwifery ‘New Vision, New Direction’ 2001 where it was envisioned that:

Nurses and midwives will be equal members of the comprehensive health team. (Pinch & Della 2001:7)

Some skeptical scholars, as highlighted in chapter two, challenged that the Nurse Practitioner legislation may not have gone far enough and that medical dominance will continue to subjugate nursing knowledge and practice. The efforts of the MLWNs to breach the hegemonic discourses were shown to be limited and more disconcertingly for many of them poorly supported and at times openly thwarted by their respective nurse executives. Research is critically needed that focuses upon understanding sociopolitical local practices that transforms the hegemonic discourse of medical knowledge and creates collaborative collegial inter-disciplinary health practice goal achievement. Such research would not just benefit nurses but any professional group steeped in historical subjugation. The difficulties
that confronted the MLWNs’ efforts to have nursing knowledge legitimated by doctors could be aligned with Chinn and Wheeler’s contention that:

Medicine’s power does not necessarily derive from academic, clinical, political or administrative skills, but rather from long-standing social, political and economic privilege. (1985:76)

**Notions Proposed for Nurse Education Programs**

There is a persistent need to include in professional nursing education, whether as formal qualification or continuing education, personal skill development that fosters nurses’ confidence of their expertise. What was missing in the various educational options relates to nurses learning how to celebrate and value nurses for their individual and inter-nurse contributions to health care and healthy workplace cultures. Further, an educational focus needs to be upon fostering nurses’ practical strategies that assists them to assertively resist disempowering behaviours by others.

As importantly, leadership forums such as those led collaboratively by CNO, DoHWA, and NBWA, as evident during the ethnography, exemplified outstanding professional recognition and empowering support for senior and executive nurses in WA, opportunities worthy of celebrating. However, what needs to be investigated is the effectiveness of leadership transformation among nursing leaders as a consequence of these kinds of forums.

From my experience of endeavouuring to gain public hospital nursing ethics and research approval, I believe there is a particular need for inclusion in nursing research education of methodology and methods similar to that applied in this ethnography. I was acutely aware that my research proposals were viewed skeptically or as highly risky to those nurses who were members of those hospital research committees. The Department of Nursing and Health Care Practices, Southern Cross University, acknowledges that much qualitative research that steps outside of the more acceptable paradigms of grounded theory and phenomenology are risky (personal communication Professor Beverley Taylor February 2001).
However, the insights and the innovative analytic processes emergent from this research are posed as valuable contributions to the body of nursing and social science knowledge and practice.

In the next section I refer to the local positive implications from the ethnographic research process for the MLWNs and myself as a participant observer and researcher. Included in this section are comments that relate to aspects of the research process that ‘fell through the cracks’ and which are offered as enhancement opportunities for consideration by novice ethnographers.

**Section 3. Research Process Implications for MLWNs and Researcher**

In part, this research sought to be a feminist emancipatory consciousness-raising opportunity to benefit the individual MLWN. My interest was to provide a trusting environment for them to explore, reveal and deepen their own implicit knowledge and its meaning. Further, I aimed to foster their valuing of their personal and professional experiences of practicing within the multiplicity of socio-politically constructed workplace cultures. How liberating the research process was for each MLWN and how valuable their contribution was to the practice-knowledge base of this research was, however, not sought to be ascertained. The positive responses of the MLWNs’ respective analytic insights indicated the emergent insights resonated with them. The ethnography, however, was a slice-in-time of their experience and that they had ‘moved on’ in different and positive ways since the data were collected. While this was so, the ethnographic analysis indicated that each MLWN had, in the words of Peggy Chinn:

> Become able to act from a source of inner strength, able to sustain against odds large and small, and capable of taking matters into their own hands. (2000:editorial)

The women nurses’ eagerness to participate and to know how the thesis was progressing indicated to me their pride in having their voices publicly acknowledged within the privacy of anonymity. Knowing that their ways of being in
the public hospital culture were potentially different to other nurses and that their roles and contributions to the overall health system's success was, in the main, poorly acknowledged, partially may have motivated them to contribute to this research. Each MLWN entrusted me to create a forum within which they could ‘speak-up’, be ‘de-silenced’, say their previous ‘unsaid’ (Glass 2007, 2003b, 2001c, 2000, 1998) and to have these privacies published.

Future research that incorporates similar emancipatory interest, I suggest, may result in enhanced feminist consciousness-raising possibilities. One option would be to invite participants to converse with like-minded colleagues, to explore their experiences, communally reveal their self-managing strategies and to critically reflect upon their personal and collective achievements.

The integration of my feminist ontology with feminist postmodern epistemological perspectives within this ethnography entailed the inclusion of me as both researcher and participant observer. The inclusion of my multiple subjectivity positions and transparent assumptions, in ways that sought to foster a critically reflexive, non-hierarchical and trusting intersubjective relationship with each MLWN, reflected my position in the research. Reciprocity, as a feminist mutual consciousness-raising method provided safety for the women nurses to speak out of their unacknowledged and private ‘unsaid’ (Glass 2003b:189), their experiences which were reflected as fluidly disempowering, oppressive, empowering and transformative.

Feminism’s research practices afforded me a personally critical reflective and liberatory transformative process and that enriched my valuing of nurses. Of importance were the practices of non-hierarchical relationships between researcher and participants, reciprocity and intersubjectivity, and open disclosure of researcher assumptions.

From my initial meeting with each of the eight MLWN my motivation to honour their passion and commitment to nursing became a personally empowering and transformative journey for me. One of the self-managing strategies emergent from
the data analysis was the MLWNs’ ‘stick-to-itiveness’ and which resonated with me during the difficult times of the research process, especially during the creation of the analytic methods and then when developing the first major draft of the thesis.

I believed I was viewed as a trusted colleague, a nurse who had demonstrated empowering values as a consequence from my nursing education contributions in the past, and which provided a welcomed entry into their private working culture. This reciprocity, present from my initial meetings with each MLWN, deeply impacted upon me as a significant responsibility to be engaged with them emotionally and ethically, and to commit to fulfil my promises to each of them.

Knowing the cultural context within which the MLWNs practised and being known by the participants became a critically important feature for this ethnography. Throughout the study I was cognisant of one concern raised by one public hospital’s Nursing Research Ethics Committee (NREC) of the risk that because I was a well known nurse educator in WA, participants would only tell me what they thought I wanted to know. In rebuttal to this concern I trusted the participants’ ethical integrity and moral fortitude to speak for themselves. I believed the NREC’s perceived risk was inverted and my position was advantageous to fostering a trusting and open relationship between myself and each participant. I was humbled by the nurses’ willingness to speak openly and freely with me during my participant observation periods and in follow-up conversations. I felt privileged to hear them speak, often for the very first time, about their deeply personal and professional real-life work-practice experiences. What also deeply impacted upon me was actually being in their presence which I found exciting because of their exuberance and enthusiasm that embodied their values embedded in their day-to-day practice. For me, the research process meant that I lived with my memories of each nurse participant every day for a minimum of five years! Like that of Chesney (2000:frame 3) each MLWN was ‘the most important person in the world to me’ throughout the research process. Thankfully, I also knew I was not the centre of their attention for long because they each acknowledged they had moved on since the slice-in-time of data collection.
Being embedded in the research process transformed me in a number of self-reflective empowered ways. Most profoundly, my confidence deepened, not in an arrogant way, but in a personal celebration of knowingness in that throughout my nursing career I believed that I had contributed positively to the profession and to those for whom we care. By critical reflective learning of the multiple theoretical perspectives that informed the research (critical social science, feminism, postmodernism, feminist postmodernism, and ethnography) my worldview became broader and more optimistic. I developed a stronger cognitive and emotional awareness of my intolerance to oppression and of my own self-managing strategies. The critical reflective analytic process that I applied to this research opened up new and alternate ways to think about other aspects of my multiple and fluid subjectivities and that of other people, in more positive and optimistic ways.

My journey of learning how to undertake this thesis commenced from a base of minimalist knowledge of the underpinning theoretical framework. Learning the principles inherent within feminist postmodernism, especially from the writings of Patti Lather and Nel Glass, and of Foucault’s power/knowledge networks of relationships, provided a forum for my deep critical and personal reflection about my own life experiences. It was a significant personal jolt when I realised that I had been a radical feminist since I was a little girl striving to protect and emancipate my mother and sister from the double standard of ‘harsh loving’ behaviours of my father. As dad’s ‘golden-haired girl’ I could do no wrong. Knowing I was a privileged person in dad’s worldview gave me courage to ‘speak out’ against his psychological, and at times physical, violence to my mother and sister. I now know that I persistently and actively resisted being inscribed or subjugated by dad’s value system of taking no accountability for his patriarchal dominating and oppressive power over the women in his immediate family. My resistive practices toward my father have troubled me, it seems, for ever, including through the last hours of life as he struggled with a tortuous terminal illness in 2006. Even in his last hours of life I was ‘storming the doors’ to breach the boundaries of his power in order to bring peace and forgiveness by dad toward my sister, who so deservedly ought to have been a source of dad’s pride, not wrath. We were successful. With dad’s death also came peace about our mother’s deeply painful and agonising
death, thirty years earlier. We believe she died from a broken heart, loving dad but knowing she could not overcome her powerlessness in their relationship.

My newly understood feminist values and sociopolitical connection with ‘the personal is political’ in conjunction with affirmative postmodernism’s valuing of individual’s uniqueness and differences is personally retrospectively recognisable. It has been evident in my passionate connection to my clinical nursing and nursing education practices. Now a new journey can begin. With a deeper level of conscious awareness I can confidently proclaim my emancipation. I will continue to ‘speak out’ when I believe injustices are being done to women, especially to those within my personal sphere.

Future researchers contemplating applying critical feminist postmodern methodology to a research design that seeks to understand the social world of women, and aims to promote emancipatory opportunities with women, and where the researcher knows the culture and is known by participants can take heart from my experience. Bringing a trusting and participant-focused set of values to the research arena was beneficial to the nature of the relationships that were established between myself as the researcher and the women nurse participants. The nature of our relationships enriched the data and the research process. Being openly transparent of my multiple subjectivity states and research assumptions meant my role as researcher was not dispassionate or objectifying of the women. Quite the reverse, I was passionately connected, embedded in the whole process and subjectively focused to valorising the MLWNs’ voices.

The next section presents the ways this research will be disseminated to contribute to body of nursing and social science knowledge.

**Section 4. Where to from here?**
The dissemination of the ethnographic insights and innovative research analytic process has both local and broad possibilities. The following outlines some of those possibilities.
The principal value of this thesis is its meaningfulness to each MLWN. Each MLWN will receive a full copy of the thesis. An invitation will also be extended to these women nurses to comment further upon the completed examined manuscript as an opportunity to bring a close to this research. Such communication does not necessarily mean our relationship will come to an end as ongoing dialogue may be a useful personal strategy that takes the research relationship out of the public arena and into a colleague-colleague relationship.

The ethnographic insights and emergent knowledge has potential beneficial contributions to the design of professional nursing leadership and management development and orientation/in-service education programs, and within a quality improvement frame, at the local practice level. These kinds of empowering-based learning programs would be recommended for middle-level and executive nurses as well as nurses aspiring to advance their career. Once these educational opportunities have been developed for nurses, similar constructs could be developed and trialed for women and men, generally, who practice in middle-level bureaucratic organisations.

The discussion of the methodology and methods applied within this ethnography will be made available to Nursing Ethics and Research Committees in the WA tertiary public hospitals, as one example. The aim of distributing these aspects of this research would be to provide a resource that may assist other nurses interested in undertaking ethnographic research framed by feminism and/or postmodernism. Further, the discussion section of the research has educational value within the general nursing research arena. As an appropriate epistemological frame for revealing and validating women’s ways of knowing this ethnography can be proffered as an important contribution to the critical social science paradigm. As a reference source for nursing and social science students I aim to pursue exploring possibilities for the development of a publishable text with an appropriate publishing house in Australia.

My active participation in professional nursing dialogue in WA and nationally can be more confidently framed by the emergent ethnographic insights.
The findings will be disseminated via journal publications, State, national and international conference presentations and professional development workshops. Wider dissemination is anticipated to contribute to teaching about change management and self-managing strategies.

There are numerous valuable insights emergent from this ethnography that could potentially positively influence the retention of nurses within the public health care system, as well as within the profession. At the State governmental level, the emergent insights may contribute to deeper understanding and recognition of nurses’ day-to-day experience of the complex cultural context present in the public health system. Attraction, recruitment and retention of nurses into the profession cannot be the sole responsibility of nurses. However, it is behooven upon nursing leaders to identify, embrace, and foster those nurses whose passion and commitment to the practice of nursing and the nurturing of nurses embodies empowering values. It was these kinds of personally embedded values of each MLWN that permeated this ethnography and which can contribute substantially to the nursing profession locally, nationally and internationally.

**Concluding Remarks**

From my nursing career spanning more than thirty five years I believe that nurses of both genders have developed practical, subjective and value-laden knowledge that is contextually embedded in the culture of their day-to-day practice. However, instead of nurses’ knowledge being celebrated and validated as legitimate, their expertise is more often overtly subjugated or openly dismissed as unimportant to the overall health care decision-making practices by those who wield bureaucratic managerialist policy decision-making power.

Given different circumstances in the undertaking of this ethnography with each MLWN, different and multiple alternate insights may have emerged. However, ‘the very notion of “personal knowing” was itself embedded in and laden with various forms of theory’ (Cody 2000:191 emphasis in original). The insights emergent from the multi-layered and intersecting methods to address the four ethnographic research questions supported Glass’ (2000) perspective that not all women will
experience oppression in the same way. However, I also concurred with Glass (2000), in that, unless patriarchal oppression is named and exposed then nothing will change. By naming and celebrating empowering practices new possibilities may be opened up for each MLWN. Alternatively, there may be a consciousness-raising opportunity in the naming of disempowering experiences from the perspective of the feminist maxim - ‘the personal is political’. As was undertaken in this ethnography, critiquing disempowering and oppressive practices uncovered the personal and professional negative impact upon the health, wellbeing and functioning of each MLWN. It also illuminated their inherent self-managing strategies that resisted being inscribed by dominating practices.

No fixed conclusions can be proffered from this research but the multiple levels of emergent meanings have deliberately opened up critical dialogue within the nursing professional arena. There are possibilities for new research questions from which may emerge different but valuable insights. In support of the comments I have proffered in this final chapter I draw upon Lather who asserted that:

Meanings are situational. . . . Continuous cultural reinvention is tied to limitless signification shaped by contextual possibilities. (1989:13)

Code’s reference to Aristotle’s, (the ancient Greek philosopher), position on knowledge further demonstrated the persistence of powerlessness of women’s knowledge in the patriarchally imbued Western society in his claim that:

For the slave has no deliberative faculty at all,
The woman has, but it is without authority,
The child has, but it is immature. (1991:9)

An important aspect of the mission inherent in ‘A Nursing Manifesto: A Call to Conscience and Action’ that resonated with my interest for undertaking this investigation was:

If nurses are to significantly contribute to a mission of caring for people and communities, we must find our voice, acting now to create situations in
which our values come to the center and from which we can realize our best intention. (Cowling, Chinn & Hagedorn 2000:frame 2)

The above quotation embraces my concluding remarks for this thesis. If I had the opportunity to practice alongside or as a subordinate to any one of the women nurse participants in this research it would be an honour and privilege, knowing that my professional nursing interests would be fostered within an empowering culture of care towards me and the patients to whom we serve.
References:


Cochrane Qualitative Research Methods Group. 


Department of Health Western Australia. *Vital Leader*


Moyes, B. (no date.). Message from the Chair: About N³ET. Australian Health Minister’s Advisory Council. 2 pgs. Google Search


National Health and Medical Research Council Act (1992) 


Appendix 1

Research Proposal Approved by Human Research Ethics Committee of Southern Cross University; Information Sheet and Consent Form.
SOUTHERN CROSS UNIVERSITY
HUMAN RESEARCH ETHICS COMMITTEE
PROPOSED PROJECT INVOLVING RESEARCH WITH HUMAN PARTICIPANTS
INITIAL APPLICATION for approval for year 2001

A. ADMINISTRATIVE DETAILS

19.7.2001
Name Of Project:
An integrated feminist investigation of the lived experiences of women nurse managers in Western Australian public hospitals.

2. Persons Responsible:
   Name: Nel Glass; Kierrynn Davis
   Position: Associate Professor; Lecturer
   School: Nursing and Health Care Practices
   Southern Cross University telephone extension no: Nel Glass: 66 203674, Kierrynn Davis: 66203673

3. Associates: (including undergraduates, honours and postgraduate students)
   Helen Pannowitz
   Technicians and/or other research personnel associated with the research (with details of relevant expertise where necessary): N/a

5. Have you received or applied for external funding of this research? NO
   If yes, state the name of the organisation:

6. Proposed date of commencement: January 2002
7. Estimated finishing date: December 2009

8. Have you sought ethics approval for this project before? NO
   If YES, what was the result? Please attach a copy of the approval

9. Is this project currently before another ethics committee? NO
   If YES, which committee?

B. PROJECT DETAILS

Aim or purpose of the research:

10.1 **Aim and purpose of the research:**
    The primary aim of this project is to investigate the lived experiences of women nurse managers within the culture of three Western Australian public hospitals.

This research specifically aims to:

- Review and critique the discourses that frame the practice of women nurse managers.
- Describe and critique the impact of the public hospital organisational culture for women nurse managers in regards to their personal, professional and corporate responsibilities.
- Explore and reveal issues that are common, different, unique and exceptional that foster and constrain the women nurse manager’s personal, professional and corporate efforts toward empowerment, emancipation and transformation.
- Explore and reveal ways that women nurse managers can create new opportunities within their work setting for enhanced empowerment, emancipation and transformation of themselves.

10.2 **Significance of the research:**
    The results of the study aim to inform women, and women nurses, in particular, of the experiences and ways that the research participants can create opportunities within their work setting for enhanced empowerment, emancipation and transformation. It is anticipated that the research findings will be of relevance to other women nurses in health management
positions, prospective nurses who are considering taking up management roles and those seeking further insights into the issues concerning the shortage of nurses in Australia. This research will also provide a frame of reference for understanding the different and various issues that confront women nurse managers working in public health care organisations.

10.3 Background to the purpose of the research:

The claim by Professor Lumby (2000 p.3) that ‘nurses are currently situated in a profession full of contradictions’ captures the essence of my long-standing curiosity and concern about how women nurse managers self-manage the potential contradictions between their professional nursing commitments and corporate responsibilities. Porter-O’Grady (1992) also indicated the potential role confusion for professionals who are managers. The practice of such women within the sociopolitical context of bureaucratic patriarchal health care systems has a history dating back to Florence Nightingale (Biley 1996). Contemporary Australian nurse managers face a multiplicity of organisational and professional responsibilities. However, there is little known about individual women nurse managers’ experiences within contemporary Australian health care organisational contexts.

The Australian health care system is similar to that of other developed countries in which medical and patriarchal values are embedded, dominate, and influence health workers, including nurses (Chiarella in Elson-Green 2000; Horsfall 1996; Mason, Backer & Georges 1991; Street, 1992). In particular, it is not known how, or to what extent, women nurse managers empower themselves to achieve their professional and corporate roles. It may be that these women are not aware that they practice within an oppressed culture or subservient position (Cash 1998; Crotty 1998; Flax 1999), characteristics of which are intrinsically identified with dominant hierarchical and patriarchal hospital cultures. The nurses may, instead, accommodate, adjust to, or assimilate the patriarchal values into their everyday practice (Mason, Backer & Georges 1991). However, these nurses may also create self-empowering strategies that are worthy of exploring, in depth, and then revealed to the wider community.

The formal functions of contemporary middle-level nurse managers, in Australia, have expanded considerably over the past several years. The nurse manager is the linch-pin between achievement of the organisational goals and nursing staff productivity, job-satisfaction and retention (Marquis & Huston 2000). The impact of the Australian public health care system’s culture on individual women nurse managers has not been identified as a potential contributing factor to the shortage of nurses within Australia. Yet, arguably, this may be a contributing factor.

11. Intended number of participants: Twelve (12)
12. Age range of participants:
   • No age restriction. It is anticipated the average age of the participants will be 35 years or more.
   • Criteria for invitation to participate in the study will be that participants:
     ♦ Are registered with the Nurses Board of Western Australia
     ♦ Have a minimum of three years experience in an appointed nursing management position in a public hospital.
13. Sex of participants: Female
14. Research methodology
Theoretical framework
The research is intentionally positioned within the framework of an ethnographic research methodology (Boyle 1994; Muecke 1994) that is informed by integrated feminist post-modernism (Lather 1991; Fahy 1997; Flax 1992; Glass 2000; Glass & Davis 1998).

The principles inherent within this theoretical framework are especially suitable and applicable to explore, critique and reveal epistemological and ontological perspectives of individual participant’s knowledge of their lived experiences within their work culture. Moreover, this will enable participants the opportunity to reconstruct empowering, emancipatory and transformative strategies. These principles align with my position as a feminist and support my epistemological belief, like other scholars and researchers, that women and nurses are oppressed (Glass 2000; Glass & Walter 1997; Horsfall 1996; Webb 1993) and that the “personal is political” (Lather 1991; Glass & Davis 1998).

The choice for the study’s philosophical framework (integrated feminist post-modernism) is embedded in my belief that not all women and women nurses equally experience the same extent of oppression and dis-empowerment as proposed by theories and methodologies that produce generalised or monolithic feminist and/or modernist claims. From my own extensive experience in nursing management, primarily in the education context of hospitals and universities in Australia, I endorse both Glass’ (2000) and Street’s (1992) assertions that the organisational culture within which women nurses practice is personally and professionally oppressive and socially constructed. In my experience the overt and covert structures, processes, politics and culture within public health care organisations inadequately fosters the valuing of nursing and in particular, nurse managers. By contextualising the research within women nurse manager’s work experiences a deeper understanding of their oppression can be revealed and critically examined in order to understand more clearly the impact of power that are every-day and taken-for-granted constructs.

Post-modernism is described in various ways by different authors (Fahy 1997; Flax 1992; Lather 1991). Cheek (1998 p.83) conceptualises post-modernism as a method of analysing reality and that recognises the multiplicity of voices, views and perspectives and seeks to explore ‘how the practice setting came to be constructed in the way that it is.’ Nursing comprises a multiplicity of individuals, mostly women, who bring to their everyday working world values that emanate from their private, family, professional, organisational and global social constructs and experiences. Nurse’s individual world-view of reality within patriarchal bureaucracies is valid (Glass 2000), needs to be heard and is relevant to current concerns about nursing in Australia.

Glass and Davis (1998) asserted that the integration of the principles of modern feminism with post-modernism is useful and valid for nursing research. The feminist principles that they refer to include ‘political action and emancipatory intent’ (p.48) and of ‘celebrating women’s voices’ (p.49). Their perspective of post-modernism ‘supports and values the social contextual experience and difference of unique individuals and rejects generalisation of those experiences’ (p.44).

From my personal and educational philosophical basis, I concur with recent nursing scholars and researchers that consciousness-raising, empowerment, emancipation and social transformation begin and are often sustained within the individual, not necessarily a particular marginalised group. These principles are particular elements of an integrated feminist post-modern philosophy and methodology (Glass 2000, Glass and Davis 1998).

The study seeks to develop a basis for individual women nurse managers to voice their lived experience of the culture of Western Australian public hospitals. By revealing and critiquing ‘the power relations at work and the manner in which knowledge is socially constructed and ideologically embedded’ (Street 1992, p.10) the status quo (Lather 1991) is
challenged. It is anticipated that through sharing our stories, within an environment that supports equality and reciprocity (Webb 1993), the participant’s individual voices will be heard, their reality will be acknowledged and validated (Glass 2000, p.356) and opportunities for personal and nursing practice transformations can emerge (Cheek 2000; Webb 1993).

14.2 Ethnography

I have chosen to use ethnography as the research methodology because its principles align with the above theoretical framework. Muecke (1994 p.194) claims that such ethnography is ‘subjective, reflecting the stance, values, and awareness of its scribe’. Morse (1992 in Boyle 1994 p.160) claimed that ethnography ‘is based on the assumption that culture is learned and shared among members of a group and, as such, can be described and understood’.

As a nurse manager with extensive experience in public hospitals means that I also, have a lived experience worth sharing and exploring with participants. Ethnography provides opportunities for reflecting on practice (enlightenment), uncovering oppression (emancipation) and revealing transforming ways to enhance one’s professional responsibilities (empowerment) (Fay 1987; Glass 2000). In addition, ethnography affords me as the researcher the scope to be involved (Glass 2000) as an equal participant, and to establish an environment of sharing (Lather 1991) in the research process, analysis and reporting (Glass 2000; Muecke 1994;).

Muecke (1994 p.194) describes ethnography as ‘wholly interpretive’ of a particular ‘moment and context’ and that ‘any interpretation is only one possible reading of the culture studied’. The nature of the researcher’s immersion in this kind of ethnographic context provides the opportunity not to generalise about the culture, but rather to present the potential contrary and unique voices of the participants’ knowledge of their culture and reality that may not be the prevailing taken-for-granted culture (Glass 2000).

14.3 Method

Data will be collected using three techniques suitable for the research methodology and theoretical framework: Participant Observation, Critical Conversations, and Reflective Journalling.

Participant Observation
- This method means I will be observing my participants but it does not mean I will be a participant in their nursing practice.
- I will be present with each participant, in her normal work place, on six occasions of three hours.
- Each observation period will occur on a different shift so that maximum opportunity is made to experience the breadth of the participant’s work roles and responsibilities and the culture of the workplace.
- During the observation episodes, my intent is to be exposed to the participant’s routine and unexpected experiences so that I can comprehensively contextualise the participants’ ‘local symbolic, social, and physical environments’ (Muecke 1994 p.204) including the political and organisational environment in which these women practice. In addition, I will be recording my field observations in a notebook. My field observations will be recorded whilst in the field and after each interaction. These observations will also be part of the data.
- During the observation episodes, communication between myself and each participant will aim to reveal and explore aspects of the culture, work roles and responsibilities and issues pertinent to the study.
At no time will I intrude where the participant is required to undertake direct patient care.

**Critical Conversations**

- Critical conversations are integral opportunities for each participant and myself to explore, reveal and reflect beyond our experiences so that new ways of practice may be constructed.

As Anderson, Armitage, Jack & Wittner (1990, p.102) declared:

> [t]he oral interview not only allows women to articulate their own experiences but to also reflect upon the meaning of those experiences to them. It provides a picture of how a woman understands herself within her world, where and how she places value and the particular meanings she attaches to her actions and locations in the world.

- After the observation episodes, I will meet with each participant, in a private and confidential location, and audio-record our conversation. The conversations will be based upon the focused questions derived specifically from the observation episodes and those questions prepared as part of the research proposal. The critical communication will seek to address the research purpose and its specific aims.

- The conversations will be fully transcribed and each participant will be invited to edit their conversation prior to the thematic analysis.

**Sample questions for the critical conversations with participants include:**

- What does it mean for you to be a woman nurse manager in a public hospital?
- Tell me of experiences in which you felt empowered to achieve your personal, professional and corporate goals within this position? Why do you think this happened? How does this experience feel for you?
- Tell me of experiences in which you have felt inhibited to achieve your personal, professional and corporate goals? Why do you think you were inhibited? How does this experience feel for you? What would you do differently next time?
- Tell me of experiences in which you influenced or asserted power in shaping nursing and other health professional’s practice within this hospital?
- What are some examples of work experiences that you have found exciting, devaluing, confronting as a woman, and oppressive? Why?
- What cultural changes do you think are needed to enhance your role as a woman nurse manager in the hospital? Why?
- What are your beliefs in regard to bringing about change in your work?

**Reflective Journalling**

- One of the key principles used by feminist researchers, as claimed by Nel Glass (2000, p.370), is ‘intersubjectivity’ and is described as that of ‘openly disclosing your own values and assumptions about the research question with the participants.’ The researcher’s use of intersubjectivity is commonly in the form of reflective journalling. As Nel Glass further described:

  > Journalling provides opportunities for feminist researchers to immerse themselves considerably in their research. In particular, journalling usually encompasses the feminist researcher’s own concerns and issues about doing as well as participating in the research (italics present in original) (2000 p.370).

- Reflecting upon my own feelings, thoughts, values, behaviours and experiences, through journalling, will afford me, as researcher and participant, to more deeply understand my own and the participants’ meanings of our lived experiences in the
culture of public hospitals. The journal writing provides a framework for in-depth
critical analysis and opportunities for insightful construction of new ways of viewing
reality and creating transformative personal and social change.

14.4 Source of participants
I propose to use a non-probability purposive sampling method that is frequently used in

• The research will comprise a total of twelve (12) participants. Four (4) women nurse
managers will be invited from each of three (3) public hospitals in Perth, Western
Australia.

• Following approval from SCU ethics committee and each of three public hospitals in
Western Australia, I will request permission from the Director of Nursing to address the
nurse managers at one of their regular staff meetings to describe the research.

• To those who meet the research criteria, a further invitation will be extended to discuss
the research.

In the event that twelve appropriate participants do not show interest in the research,
then I will use a snowballing sampling technique that is suitable for sensitive research
studies (Platzer & Jones 1997). The technique requires the researcher to ask potential
participants to recommend other women nurse managers, thus establishing a snowball
effect by locating other prospective participants who may be interested in the study.

14.5 Selection of participants

• Criteria for selecting participants will include women nurses who have been appointed
to a middle-level nursing management position and have:
  ♦ Registration with the Nurses Board of Western Australian
  ♦ A minimum of three years experience in the position
  ♦ An interest to disclose and discuss their experiences with me
  ♦ An interest to explore the empowering, emancipatory and transforming process of
    the lived experience as women nurse managers
  ♦ An acceptance to be observed by me over a period of four weeks and then to
    participate in a critical conversation.

• Meet with interested individuals, as a group, to further explain the research and
selection criteria of participants, answer questions, extend an invitation to participate,
and hand out the Information Sheet.

• Meet privately with interested individuals to answer any other questions and clarify the
study process. Those nurses who agree to participate will be given the Consent Form to
sign.

14.6 Selection of Hospitals

• There are thirteen public teaching hospitals within the Perth metropolitan area and
numerous regional and rural public hospitals. I shall submit the research proposal to the
Ethics Committee of three metropolitan hospitals to seek approval. This spread of
locations will provide more opportunity for rich data from the perspective of women
nurse managers and the culture of Western Australian public hospitals.

14.7 Does the researcher intend to use a questionnaire?  NO

14.8 References

   Anderson, K., Armitage, D., Jack, D. & Wittner, J., (1990). Beginning where we are:
   Feminist methodology in oral history. in J. Nielson. (ed) Feminist research methods

   Clinical Nursing. 5. (3). pp. 159-163.


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C. ETHICAL CONSIDERATIONS

15. Does the research involve any of the activities which fall within the ambit of Section 3A of the Southern Cross University Guidelines/Rules, the NH&MRC Statement and Supplementary Notes or AHEC Guidelines? NO

16. Does the research involve any other institution (such as a hospital)? YES
   If YES, does the institution require ethical approval from its own ethics committee? YES
   If YES, has that approval been obtained? NO

17. Is the research on Indigenous Australians (individuals, groups or communities)? NO

18. Does the research involve any of the activities identified in 3C of the Guidelines? YES
   If YES, detail below what measures you will take to address the ethical considerations raised:

   If YES, what is the nature of the activity?

   The research will use conversation procedures with individual participants, and observation of the participant’s public behaviour (only within the scope of the participant’s work setting). There will be no patient contact on the part of the researcher, nor observation of the participant during any nursing/medical treatment/procedure of any patient.

   Each participant and each hospital will be assigned a pseudonym prior to commencement of recording of any data. The identity and corresponding pseudonym of each participant and hospital will be kept in a locked cupboard in the researcher’s own home. At no time will the true identity of the participants or hospitals be made known, nor disclosed to anyone. Pseudonyms will be used in all recordings of information from each participant and descriptions of the culture of the hospitals and in the analysis and final report. This matter is of particular relevance to this research because the researcher is well known in Western Australia and the number of public hospitals is small in comparison to bigger cities in Australia. The purpose of the research is not to critique or advertise any hospital, rather to understand the relationship of the public hospital culture and the participant’s lived experience within it.

19. Will the research require personal information to be disclosed by a third party? NO

20. How will the researchers address the requirements under section 7 of the Guidelines? (Informed Consent)
   • Informed consent will be sought from each participant, independently, and the research project fully explained.
   • The Information Sheet and Consent Form (as attached) will be provided to each prospective participant and will be in plain language. The consent form outlines: the aim and purpose of the research, the methods used to collect information, the role of the participant and researcher, the setting in which the research data will be collected and reported, the method for confidentiality. Also included is an explanation of withdrawal from the research, and that participants can freely withdraw at any time.
• Prospective participants will be given every opportunity to ask questions and raise issues about the project with me or my supervisors. I will make myself available in person, by phone, or email to discuss/clarify any information they require.
• The consent form will be signed and dated by both the individual participant and myself. All consent forms will be kept with all other data for a minimum period of five years in a safe and secured place.

21. **Indicate any potential risk you can envisage for the participants and the safety precautions to be taken.**
This information will be sent to the University Risk Manager for possible transmission to the University’s insurers.

In accordance with the guidelines, the following risk management processes will be put into effect:
• Disclosure of participant’s or hospital’s identity will be protected by the use of an assigned pseudonym at the commencement of the data collection. There will be no discussion to anyone else by me as to who or what hospital is involved in the research at any time, reporting of data and analysis.
• Data analysis and reporting will be in the form of deconstructed data of the overall culture of the three hospitals and themes that emerge from participant observations and conversations and my reflective journaling. Analysis and reporting will take the form of identifying, comparing and critiquing themes that are common, different, unique and exceptional using a narrative format that incorporates related participant’s “voiced” experiences, my observations and analyses from my reflective journaling.
• Each participant will receive a copy of their respective conversation transcript for confirmation and/or deletion of information they choose not to have included in the analysis.
• I am a well known person in the Western Australian nursing profession and I am especially conscious of the potential risk to the research participants being identified by their own colleagues and employers as being involved in this research. A clear explanation to the ethics committee of each hospital and each prospective participant of how I will conduct the research and report my data analysis is critical to assuring their confidentiality and safety. Quite specifically the purpose of my research is to gain a deep understanding of the lived experience of women nurse managers and to report their reality of that experience.

22. **A copy of the informed consent form to be signed by participants is attached.**

YES

23. **Certification that the project is of a satisfactory standard by the Head of School, College Director or Director of Postgraduate Studies and Research. Where the applicant is Head of School this section should be completed by the Director of Postgraduate Studies and Research:**

Signed _____________________________ Date: ___________________________

Position: ___________________ School/Centre: ___________________________

Do you consider that this application can be dealt with by the Dean of the Graduate College and Research rather than the full Committee? **YES** **NO**
24. Comments (if thought necessary) by the above signatory about the academic rigour of the project, especially in regard to the research methods to be used:

25. Certification:
I, the person responsible, certify that the proposed research will conform with:
• the general principles set out in the NHMRC Statement on Human Experimentation and Supplementary Notes
  (1992) or with the principles of .................................

AND
• Southern Cross University's research ethics standards.

Signed: __________________ Date: __________________

Position: ___________ Name: _______________

Associates: ___________ Date: __________________
CONSENT FORM

RESEARCH TITLE: An Integrated Feminist Postmodern Investigation of the Lived Experiences of Middle-Level Women Nurses in Western Australian Public Hospitals.

INVESTIGATOR Helen Pannowitz, RN. MN.

I ................................................................. (print name)

of ............................................................. hereby consent to be a participant in a human research project, to be undertaken by Helen Pannowitz, entitled ‘An integrated feminist postmodern investigation of the lived experiences of middle-level women nurses in Western Australian public hospitals’.

The research and my involvement in it has been explained to me and any questions or concerns have all been answered to my satisfaction. I understand that the research involves Helen Pannowitz observing me at my usual work over six periods of approximately three-four hours each; Helen Pannowitz taking notes of these observations; a tape-recorded conversation with Helen Pannowitz during which I will be asked to share my thoughts, feelings and experiences regarding my role as a woman nurse manager.

I further acknowledge:

- I have been given clear information (verbal and written) about this study and have been given time to consider whether I want to take part.
- I have been told about the possible advantages and risks of taking part in the study and I understand what I am being asked to do.
- I have been able to have a member of my family or a friend with me while I was told about the study. I have been able to ask questions and all questions have been answered satisfactorily.
- I know that I do not have to take part in the study and that I can withdraw at any time during the study without affecting my future work. My participation in the study does not affect any right to compensation which I may have under statute or common law.
- I voluntarily and freely give my written consent to participate in the research project.
- I will participate in the six periods of observation and a tape-recorded conversation approximately 1-2 hours in duration with Helen Pannowitz.
- I will be given a typed transcript of the taped conversation in order to make any corrections, changes and/or deletions that I may feel necessary.
- My name and any details that may individually identify me will be changed in order to protect my privacy and maintain anonymity.
- I understand that the results of the whole study will be used for research purposes and may be reported in professional journals and/or at professional conferences.
- I agree to take part in this research study and for the data obtained to be published provided my name or other identifying information is not used.
- I understand that the investigator will adhere to usual standards of confidentiality in the collection and handling of my personal information and that the provisions of the Privacy Act 1988 will apply to the way my information is handled.

The study will be carried out in a manner conforming to the principles set out by the National Health and Medical Research Council.
This research project has been approved by the Hospital’s Nursing Research Review Committee which reports to the Institutional Ethics Committee. Further information may be obtained from the Chief Investigator or from the Nurse Researcher of the Hospital.

I, ................................................agree to participate in the above study. I have read and understood the study information and have been given a copy for myself. I have been given the opportunity to ask questions about the study. I understand that I may withdraw from the study at any time without penalty.

Signature (Participant) ................................. Date .................................

Signature (Investigator) ................................. Date .................................

Copy of Consent given to participant YES

If you have any complaints or queries regarding this project that cannot be answered by myself or my supervisors please contact Graduate Research College, Southern Cross University (Ph: 02 6620 3705).

Helen Pannowitz. RN. MN.
Doctor of Philosophy candidate
School of Nursing and Health Care Practices
Southern Cross University
INFORMATION SHEET FOR RESEARCH PARTICIPATION

RESEARCH TITLE: An Integrated Feminist Postmodern Investigation of the Lived Experiences of Middle-Level Women Nurses in Western Australian Public Hospitals.

INVESTIGATOR Helen Pannowitz, RN, MN.
Doctor of Philosophy candidate
School of Nursing and Health Care Practices
Southern Cross University

I am a registered nurse currently enrolled in doctoral studies with the School of Nursing and Health Care Practices, Southern Cross University, Lismore, NSW. I am presently undertaking a nursing research project entitled “An integrated feminist investigation of the lived experiences of middle-level women nurses in Western Australian public hospitals”.

The purpose of this information sheet is to provide you with details of myself, the proposed research and to invite you to participate.

My own nursing experience as a practitioner, educator, manager and academic, over a period of twenty-five years, has led me to believe that the role of the middle-level nurses is the linchpin within the Australian public health care system. In the current climate of global change (reflected in health care practices) there are exciting opportunities for enhancement of the professional profile of nurses, especially that of nurses in middle-level positions. Evolving management practices are influencing all organisations, including public hospitals and the scope of practice for the nurses. There is minimal research that explores, reveals and values what it means to be a middle-level woman nurse from her own perspective.

For the purpose of this study I invite you to share your experiences, thoughts, and feelings of what it is like for you to practice, as a woman nurse, within the culture of a Western Australian public hospital. Furthermore, I invite you to share and discuss with me factors that you consider impact on you in terms of enhancing, achieving and/or hindering your personal work desires, and your professional and organisational responsibilities. One of the anticipated outcomes of the study is to provide you with the opportunity to voice your experiences, more deeply understand those experiences and enhance your valuing of those experiences. Your experiences can, thus, provide insight to other women, nurses and prospective nurses of ways that nurses can create opportunities for enhanced personal change.

The study involves me spending several hours, over several shifts, alongside you while you fulfill your usual work. I will not be observing you while you provide nursing care. Following these observation sessions, which will be documented in my field notes, we would meet for about one-two hours to discuss more fully your experiences. This conversation will be tape-recorded, transcribed and returned to you so that you can correct and/or make changes should you feel necessary.

Your privacy and confidentiality, like that of the hospital within which you work, will be protected throughout the entire research process. Your name, and that of the hospital, will be replaced with a pseudonym and all identifying places or events will be changed making it difficult for anyone to identify you or your place of work. All collected data will be securely kept for a period of 5 years and then destroyed.

Participating in this study is voluntary and as such you are free, at any time, to withdraw from the project. During the observation periods and the conversation, you can request at any time that information not be included in my field notes or that the tape-recorder be turned off. If, at any time, you experience emotional discomfort or distress, as a consequence of my presence, then I will provide you with a list of counselors and payment will be free.

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The study will be carried out in a manner conforming to the principles set out by the National Health and Medical Research Council.

If you have any further questions or require any additional information please contact me by phone or email (details provided above) or my supervisors, Associate Professor Nel Glass or Dr Kierrynn Davis, Senior Lecturer. Should you decide to participate, a written consent form is attached. Please complete it and return to me.

Thank you for taking the time to consider this opportunity.

Helen Pannowitz

If you need more information about this study before you decide to join (or at any other time) or at any time during the data collection you should call one of the supervisors involved in the study on the above numbers.

If you have any complaints or queries regarding this project that cannot be answered by myself or my supervisors please contact Graduate Research College, Southern Cross University (Ph: 02 6620 3705).